the MODERN HOSPITAL

VOLUME 66 APRIL 1946 NUMBER 4

FORWARD STEPS IN SCIENCE

THE discovery of X-rays by Roentgen, 1895, was a forward step in science of inestimable value to medicine, surgery, and industry. So too, the discovery of the proper alloy of stainless steel for the manufacture of surgical instruments, was a forward step of incalculable value in the practice of surgery.

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Wilhelm Konrad Roentgen, one of the most celebrated physicists of modern times, discovered X-rays—frequently called Roentgen rays—in 1895, and for his achievement was awarded the 1901 Nobel prize for physics. Roentgen was born in 1845 and died in 1923.

Historical data courtesy Picker X-Ray Corp.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Detroit Medical Hospital, Detroit, Michigan: Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Value of Mattress Sterilizer

Question: What factors in terms of usage determine the advisability of the installation of a mattress sterilizer? Is a mattress sterilizer justified?—L.M.B., Mass.

ANSWER: Many hospitals do not have mattress sterilizers. The representative of a large hospital supply house states that in his travels he sees many mattresses exposed to sun and air on hospital lawns and roofs. A health officer, who speaks with authority, advocates the use of a mattress sterilizer for mattresses which have been used by patients having tuberculosis, certain dysenteries or typhoid. It might be worth while to inquire concerning the use of certain ultraviolet lamps for mattress sterilization.—ELIZABETH W. ODELL, R.N.

Time Clocks and Morale

Question: Will the installation of a time clock in a small hospital, in which employes generally work overtime and personal contacts are so constant, affect morale? Shouldn't the nurses use the clock as well as other hospital workers?—L.M.B., Mass.

ANSWER: If the installation of a time clock was preceded by a well-planned explanation of the reasons why it was being installed and the advantages to personnel, such as simple, accurate timekeeping and simplification of clerical duties, it should be well received and should not unfavorably affect morale. If all other technical and professional personnel use the time clock, it would seem logical for the nurses to follow the same procedure.—JANE CARLISLE.

Job Combinations

Question: Do many hospitals find dietitians able to combine dietetics and housekeeping? If so, how small are those hospitals?—M.J., Ore.

ANSWER: The most frequent combination of duties for the dietitian is that of dietitian and housekeeper. We doubt the advisability of the dietitian's assuming responsibility outside of her department in any except the very smallest hospitals, although we frequently find her in the two-fold position in hospitals having as many as 75 beds.

When the latter is the case we usually find the superintendent or "the buyer" trying to purchase food and supplies for the dietary department and holding the dietitian responsible for the poor meals and high cost of the department. The dietitian has had no special training in hospital housekeeping although she has had a great deal in food values and purchasing in this department; so why not leave her to the duties that she is best prepared to perform? There are some of our small hospitals that employ a housekeeper and give her the title of dietitian; in this case she may not be able to assume complete responsibility of the department but is quite capable of executing the duties required of her in the two-fold position.—JEWELL W. THRASHER, R.N.

Need for Social Service

Question: Does a small hospital of about 64 beds need social service department workers?—D.C., Wash.

ANSWER: The need of social service workers in a 64 bed hospital will be determined largely by the type of patients served, whether or not an out-patient department is maintained and the cooperation of various welfare agencies.

If the clientele consists of a high percentage of charity patients, the services of social workers are certainly needed since these cases usually require a great deal of investigation. If a hospital of this character maintains an out-patient department, the social service workers are invaluable in their assistance in follow-up work.

The 64 bed hospital whose clientele consists mostly of private cases is usually able to gain the cooperation of various welfare agencies within the city to investigate the charity cases. In many instances the agencies have had previous contact with these patients and have records of their social history. They are happy to share their information with the hospital, and they appreciate the privilege of referring their indigent cases to it.—JEWELL W. THRASHER, R.N.

When Doctors Are Recalcitrant

Question: What would you do with a doctor who always has the plea "too busy" to complete his charts on time?—L.H., Ga.

ANSWER: Post a list of delinquent records on the doctors' in-and-out register. Enlist the aid of the chief of staff and have him use his influence to get the doctors to do this work. Offer to help the physicians catch up on their notes by assigning someone to take their dictation. When all other methods fail, threaten the doctors with expulsion from the staff until such time as notes are brought up to date.—FRANCES A. DIVER, M.R.L.

Discounts for Laboratory Work

Question: What is the usual procedure in regard to discounts given on laboratory charges to a patient who has routine laboratory work done daily over a period of several weeks?—C.H., Mo.

ANSWER: It is difficult to ascertain the value of laboratory service to the patient. One satisfactory method, especially for the patient who has a large amount of laboratory work, is the all-inclusive rate under which the patient may receive the benefit of any or all laboratory procedures for an unlimited period of time.

In hospitals using the routine laboratory fees, it is customary to allow discounts scaling the charge down to meet the patient's ability to pay.

Another fairly common procedure is the allowance of a discount after an established ceiling has been reached. For example, any diabetic patient might within a comparatively short period of time use up to $20 worth of laboratory work, after which he would be entitled to a liberal discount.

The point to be remembered is that, no matter what policy is established, the cost of this service should not be burdensome to the patient.—PEARL FISHER.

Assigning Emergency Work

Question: How is the emergency work assigned to staff doctors?—A.J., Fla.

ANSWER: A policy should be prepared, approved and adopted by the governing board, the hospital director and the medical staff; this should be in writing and signed by each participating member. To avoid accusations of partiality, each medical staff member should reply to a questionnaire embracing the following: Invitation to appointment on emergency staff. To what service or services? Available at all hours? On call between what hours? Exceptions: days ..... , nights .....? The questionnaire should define "emergency work," "obligations and responsibilities" and "method of rotating calls."

Persons responsible for placing emergency calls should be carefully instructed and taught the importance of recording a detailed log.—GLADYS BRANDT, R.N.

LOOKING FORWARD

Act Now for a Good Law!

FROM its earliest introduction, the federal Hospital Survey and Construction Bill has had the support of hospital and medical people generally. To a greater extent than ever before at the national level, professional groups have had a voice in shaping this proposed legislation. As it was passed by the Senate last December this bill (S. 191) was the product of many different pressures, but the hospital-medical interests had been well represented and the bill was felt by most of these professional groups to be a good bill on the whole.

Now there is danger that the painstaking effort that has gone into the formulation of this legislation may be destroyed or, at any rate, badly diluted. A similar bill (H. R. 5628) has been introduced into the House of Representatives, embodying a number of amendments to the measure adopted by the Senate. Briefly, these amendments tend to concentrate authority for administration of hospital construction funds in federal as opposed to local hands and to diminish the effectiveness of the professional advisory body established in the Senate bill.

H. R. 5628 is definitely less desirable than S. 191. To many observers the differences may appear to be small, but in total effect they may measure the whole distance between a bill that is worth supporting whole-heartedly as a useful vehicle for improving hospital care for all the people and one that holds at least a threat to independent hospital finance and operation.

It is up to hospitals to make certain that Congress understands the difference; if the group most seriously affected by this legislation does not make itself heard in unmistakable terms, nobody else is going to care much what happens to either of these bills.

Every hospital administrator should write to his congressman immediately asking for support of the Hospital Survey and Construction Bill as it was passed by the Senate. Furthermore, doctors, nurses, trustees and auxiliary groups should be urged to write to their representatives in Congress; letters should specify that hospital legislation now under consideration in the House be modified to conform to the bill passed by the Senate, so that professional people will have the maximum voice in the administration of funds for hospital construction and so that participation of local groups will offer the greatest possible protection against federal control of hospital affairs.

With statements to this effect already on file from official representatives of national hospital and medical associations, a flood of supporting letters from obviously informed constituents should easily arouse the interest of enough congressmen to assure passage of a proper measure. This vital problem deserves an important place on the agenda for the next meeting of every hospital staff, board and woman's auxiliary.

Blue Cross Payments

DISPUTES between Blue Cross plans and hospitals about rates paid for service to subscribers still boil over noisily from time to time, as they did recently, for example, in Detroit and Chicago. It seems reasonable to believe that these are not isolated cases; where so much water is boiling, a lot more is probably simmering. Ten years of Blue Cross experience has not yet produced a satisfactory formula for payments to hospitals.

While it is hard to defend a payment formula based on costs against the charge that it penalizes the kind of efficient management which keeps costs down, it seems likely that some cost basis offers the best hope for a solution, since it is even harder to defend other methods. Payments based on hospital rates include too many obvious individual variations and injustices; flat rates invite periodic eruptions over frequently recurring high cost cases.

An American Hospital Association committee hard at work on this problem promises to come up with some recommendations, possibly embodying a cost formula on the E.M.I.C. principle, for approval by the house of delegates at its fall meeting. Any such method must obviously meet the highest standards of fairness and workability to pass the delegates' scrutiny. Thus, it is not too early to propose now that adoption of the formula or other method recommended by the house of delegates should become mandatory for plans wishing to retain A.H.A. approval and for hospitals wishing to retain Blue Cross membership. Less positive measures will only encourage the 80-odd plans and their thousands of member hospitals to drift along on the devious paths of trial and error, argument and adjustment.

Possibly it was once true that these are the safest paths for experimenters to follow, but now it is getting late. With 20,000,000 people paying for hospital care in plans covering 45 of the 48 states, payments that are not plainly and uniformly established on logical principles in the public interest will ultimately land in the lap of regulatory bodies similar to those which now

govern rates for public utilities, transportation and insurance. If Blue Cross payments to hospitals fall under such jurisdictions, what chance is there that hospital rates generally will remain independent?

For More Effective Nursing

STARTING in this issue of The Modern Hospital, Keith O. Taylor of California presents an important series of articles on "Methods of Measuring the Quality of Nursing." For years, administrators have had the means of determining whether or not nursing service was adequate on the basis of time spent at the patient's bedside. However, it has been widely understood that bedside time might mean much or little in terms of actual nursing effectiveness.

In the studies described in these articles, Mr. Taylor establishes yardsticks which give different values to the half hour spent producing charts that the doctors will read and use, as against the half hour that is largely wasted writing charts consisting of insignificant trifles. Here are methods that recognize the difference between the fifteen minutes devoted to bathing a patient who is rested and refreshed as a result and the fifteen minute bath that leaves the patient tired and testy.

These are vastly important determinations. To those who will study his reports carefully, Mr. Taylor offers a method of finding out whether or not the nursing service is delivering adequately—in terms of real nursing quality.

Good Boss

THE American College of Surgeons, which ought to know, says that a hospital administrator should be a "competent executive officer having the authority and responsibility to carry out the policies of the institution as authorized by the governing board."

In simpler language, a competent executive officer is just a good boss. Like any other good boss, the hospital administrator sits behind a desk and makes things go. Like any other boss, when they don't go, he is out in the shop to find out why and raise the roof.

To "carry out the policies of the institution," a good boss has to look in all directions at once. For example, he may start the day interviewing a candidate to take the place of the laundry supervisor who quit last week to go in business for himself and end it dining with an important doctor who has just moved to town and hasn't decided which hospital staff to join.

In between, he has had a session with the credit manager and bookkeeper about those old accounts that have to be collected before the treasurer of the board gets his report next month; he has talked to half a dozen salesmen who quoted him prices, high, and delivery, slow, on everything from carloads of coal to grains of some esoteric drug that the staff insists on having but won't use; he has called on a crotchety but influential patient who complained about the meals and pointedly ignored a hint about a donation for the clinic; he has entertained a committee of the medical staff with a complaint about nursing service, and a committee of the nursing staff with a complaint about doctors; he has investigated a request for free care and found that the family drives a better car than he ever expects to own, and he has written letters to the Chamber of Commerce, the Rotary Club and the Women's Civic Improvement Society saying yes, he'll be delighted to attend their luncheons, all of which come on the same day.

He is, in the words of the American College of Surgeons, "well trained in the art of hospital administration."

Medical Ethics

LOTS of people talk about medical ethics but not many people understand what medical ethics is. Everybody knows that ethical doctors aren't supposed to advertise or split fees, and that an elaborate protocol governs when two or more doctors share the same patient, but beyond this point the average person's knowledge of the subject breaks down quickly. Actually, the "Principles of Medical Ethics" of the American Medical Association embrace a whole concept of professional morality that hospital people, certainly, should be familiar with. Here, for example, are excerpts from a few of the principles:

¶ A profession has for its prime object the service it can render to humanity.

¶ Patience and delicacy should characterize all the acts of a physician.

¶ The physician should comport himself as a gentleman and use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and extend its usefulness.

¶ Self-laudations defy the traditions and lower the tone of any profession and so are intolerable.

¶ Physicians should expose without fear or favor corrupt or dishonest conduct of members of the profession.

¶ Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians.

¶ Physicians should bear their full part in enforcing community laws and sustaining institutions that advance the interests of humanity.

If these are good rules for the doctors, and nobody can deny that they are, they are also good rules for everybody else who is concerned with the care of the sick, and it might be a good idea to establish these as principles of conduct for all hospital personnel. Undoubtedly, it is too much to expect that the behavior of any considerable group of human beings, including physicians, is going to be characterized by patience, delicacy, dignity and honor all the time. But the higher we aim, the more we are likely to achieve.

IT COULD HAPPEN TO YOU

and perhaps  *it should*

L. W. JAY, M.D.

These rueful reminiscences of a physician who learned the patient's point of view the hard way will cause the thoughtful administrator to reflect upon certain shortcomings in the service of his own hospital which could so easily be corrected

WHEN the physician himself falls ill and has to go to the hospital, it often works out to be for his own good, as well as for the benefit of the hospital and of his future patients.

It benefits him because of the rest and relaxation that follow after he has learned the difficult lesson of being a good patient. The hospital will be benefited because of his opportunity to study from a new point of view the details of its routine, its equipment and its personnel. He will undoubtedly note the defects and irregularities that require correction. It will be valuable to his future patients because of his opportunity to observe from the receiving end the workings of many of his favorite nursing and therapeutic procedures.

He Learned a Lot

Such an experience was recently mine. During my stay in two hospitals I observed many things that otherwise I would never have noticed. One was a small hospital of 30 beds and the other was a very large one.

Let me preface what I have to say by stating that throughout my time as a patient I received most distinguished care from competent and kindly people who omitted nothing that might aid in my comfort and recovery. They deserve my undying gratitude and no slightest criticism of them is intended. My daily work gives me an intimate knowledge of the war-time difficulties of obtaining workers and materials, and full consideration has been given to these.

The average doctor, accustomed to a life of considerable physical activity, finds it difficult to adjust himself to the limitations of life in bed. He usually goes through a stage of self-pity and anxiety which Sir Walter Scott must have had in mind when he wrote of "This wretch concentrated all in self." At this time he is likely to be acutely conscious of all the minor discomforts and handicaps that loom so large in the mind of the patient. He will be fortunate if he can remember them after he has recovered, so that he can reduce or ameliorate those discomforts for his patients.

After struggling up from this slough of despond he usually achieves orientation and realizes the importance of complete cooperation with those who are caring for him. In short, he becomes a good patient. Such a transformation is probably more difficult for a physician than for any other person. It requires a long course of training to be sick gracefully and graciously. Few men ever attain it.

The light provided in one sickroom was a high-candlepower, unshaded bulb in the center of the ceiling—what the electrician will install if you don't stop him. To the right was the door to the corridor, and there hung an even larger unshaded bulb. When this was lighted about 6 o'clock each morning, it marked the end of comfortable rest. Opposite the foot of the bed was the bathroom, in which there was another powerful bulb. Shocks to the eyes from these light sources were frequent and painful. No light was provided that might be used in reading.

Modern conceptions of sickroom lighting are too well known to require discussion here, but it was noted that in this hospital, built since the war began, the sickrooms were lighted like business offices.

It Sounded Like a Concrete Mixer

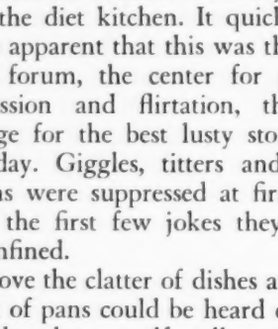
Sound was dominated, night and day, by a slapping, crashing racket which I diagnosed as a large concrete mixer just outside my window. There was also a high-pitched, tinny clatter of the type described as setting the teeth on edge. When I inquired about the construction work, the answer was: Oh, that's the air-conditioning machinery for the operating room."

Apparently there was need not only for adjustment of the machinery but also for acoustical treatment for dampening the vibrations of the galvanized iron housing. Being set in a court, the noise was intensified

by the walls of the surrounding buildings, which acted as sounding boards. The staff was so accustomed to the racket that it tuned it out and thought nothing of it.

Across the corridor from my room was the diet kitchen. It quickly became apparent that this was the hospital forum, the center for gossip, discussion and flirtation, the exchange for the best lusty stories of the day. Giggles, titters and belly laughs were suppressed at first, but after the first few jokes they were unconfined.

Above the clatter of dishes and the clank of pans could be heard certain squeals, slaps, wolf calls and admonitions to desist, which gave me



the comforting assurance that young people of today are much like those of my long-since youth. My impression was that voice culture should be one of the earliest courses to be given to probationary nurses and cadets. Acoustical treatment of the diet kitchen and corridor would have done much to improve the rest and relaxation of the patients.

A Matter of Maintenance

The mechanism of the gatch spring squeaked and groaned as the bed was being cranked into position. The gears must have been loose or badly worn as they frequently jumped a tooth or two, causing pain to the patient and embarrassment to the attendant. Here was evidently something that the maintenance man had failed to note.

Why couldn't the automatic adjustment that is now built into the seats of airplanes and railway cars be adapted to use in hospital beds? Then the patient could have the bed the way he wanted it and change it frequently without feeling that he was imposing on the overworked attendant.

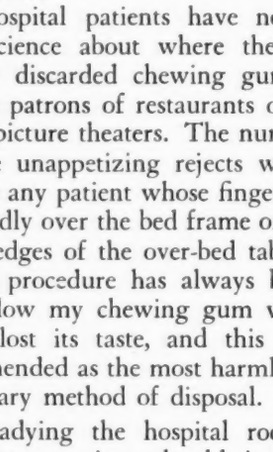
Another neglected gadget was the over-bed table. Apparently the gears were faulty, for they no longer functioned well in raising the top. The small cranks at each end, used to raise and lower it, are held in place with screws. These evidently are easily lost, for on several occasions it was necessary to send to another patient's room or a distant storeroom to borrow a handle to adjust the height. Nobody seemed to feel obligated to bring this to the notice of those who should be responsible for maintenance.

Some day some enterprising manufacturer will bring to a waiting world a bedside or over-bed table which the patient himself can move about and adjust to his needs without too much exertion or contortion. That will be a real boon to mankind.

Hospital patients have no more conscience about where they park their discarded chewing gum than have patrons of restaurants or moving picture theaters. The number of these unappetizing rejects will surprise any patient whose fingers wander idly over the bed frame or under the edges of the over-bed table. My own procedure has always been to swallow my chewing gum when it has lost its taste, and this is recommended as the most harmless and sanitary method of disposal.

Readying the hospital room for the new patient should include a quick search for those little brown mounds of other people's chicle. Many sick persons find contact with them a highly repulsive experience.

Some of the standard nursing procedures can be done in such a careless or incompetent manner that they lose most of their usefulness and become merely an annoyance to the patient. The bed bath and the enema



are leading numbers here. Unless the nurse or attendant is careful and conscientious, these routines can degenerate into unpleasant experiences to which nurse and patient alike look forward with dread.

If I could devote my whole future to the search for a satisfactory substitute for the bedpan, and be successful to some considerable degree, it would seem a life well spent, deserving of rich rewards. Every doctor should experience a week in bed with a bedpan.

When the physician leaves word that the patient is not to lift his head from the pillow and must avoid all strain, he walks away with a sense of duty well performed. It probably does not occur to him that it is a maneuver of the highest complexity to empty the bowels while flat on the back and without straining. If seriously attempted, it is likely to result in extensive soiling of the bed, which will require much moving of the patient while changing the linen.

It Can't Be Done

The usual compromise is, I fear, that the patient is supported on the bedpan in such a position that he can use his abdominal muscles in the usual way to aid evacuation. Probably few of us are able to have a bowel movement without increasing the intra-abdominal pressure and thus reenforcing peristaltic action.

If the urinal is cold, contact with it may bring on a spasm of the muscles about the neck of the bladder, which will make it more painful. Moisture on the outside may dampen the bed or the patient's clothing. A residue of fluid inside may run out during inexperienced handling and seem like an impromptu deluge. The urinal should be completely dry and at body temperature to avoid discomfort and perhaps embarrassment.

Food was delicious, and it was provided in quantities that would have delighted the members of a football or rowing squad at their training table. It was a high-calorie, low-residue diet which left little undigested material to stimulate peristalsis. Reduced activity of a patient in bed lessens the peristalsis, so much residue and more fluid are needed if constipation is to be avoided.

Another discovery surprised me. When the dietitian sent out a tray, she charted the contents as being eaten by the patient. If he was feeling low and ate little or none of it, that made no difference in the record. In those days, with shortage of personnel and many jobs for every person, the dietitian may have had no time to wait in the diet kitchen to inspect the trays when they were brought back. Yet this point might be of great importance to the physician who is caring for patients with any of the metabolic or nutritional diseases.

Massage was ordered, and what was given left me with a nostalgic longing for my early days when massage was highly regarded. Then it was prescribed to produce a definite effect on definite structures and it was a most valuable adjunct.

Many nurses, cadets and attendants applied the so-called massage. Some rubbed up and down while others rubbed across and back, but none showed any knowledge of the structures that lay beneath the skin or of the therapeutic purpose of the manipulations.

Massage Is in the Wrong Hands

It is my personal belief that many of the ills which now plague the medical profession stem from the days when the doctors lost sight of the tremendous influence of the laying on of hands. Invaluable therapeutic procedures, such as massage, have been allowed to slip into the hands of others who have used them as levers to aggrandize themselves and to belittle the medical profession. It is saddening to see such vital weapons handed over to our detractors.

Apparently everybody in the hospital, except me, knew that penicillin is wonderful for flowers, whether cut or growing. All the unused remnants in the ampules were used for this purpose. A nurse demonstrated this to me, using a half-wilted rose. Not long after a few drops of penicillin had been added to the water the rose perked up, looking crisp and fresh. She told me some flowers will rustle their petals and almost cheer aloud because they feel so good when penicillin is added. I did not observe this myself.

Some woman humorist, whose name escapes me, recently wrote that while she was in the hospital and

wanted an hour of uninterrupted solitude, she had only to pull the cord which activated the call light and be assured that no one would come near her. I regarded this as a production-line wisecrack by a professional who had to turn out a certain amount of copy each day, without too much regard for the truth.

My hospital stay taught me that she probably was recording in a humorous vein an

unfortunate personal experience. The reason for such delays are well known to all of us. What a lot of ground we have lost in the quality of hospital service to patients during the war years! We must never forget our obligation to recover the old standards.

These were modern hospitals with staffs well above the average in ability. Their devotion to the welfare of the patients was above criticism. It is difficult to write about these minor shortcomings without a feeling of ingratitude. The only reason why I do so is to suggest that if they could happen in such hospitals as these, they could happen in any hospital—even yours.

Appointment Priorities

JOHN F. CRANE

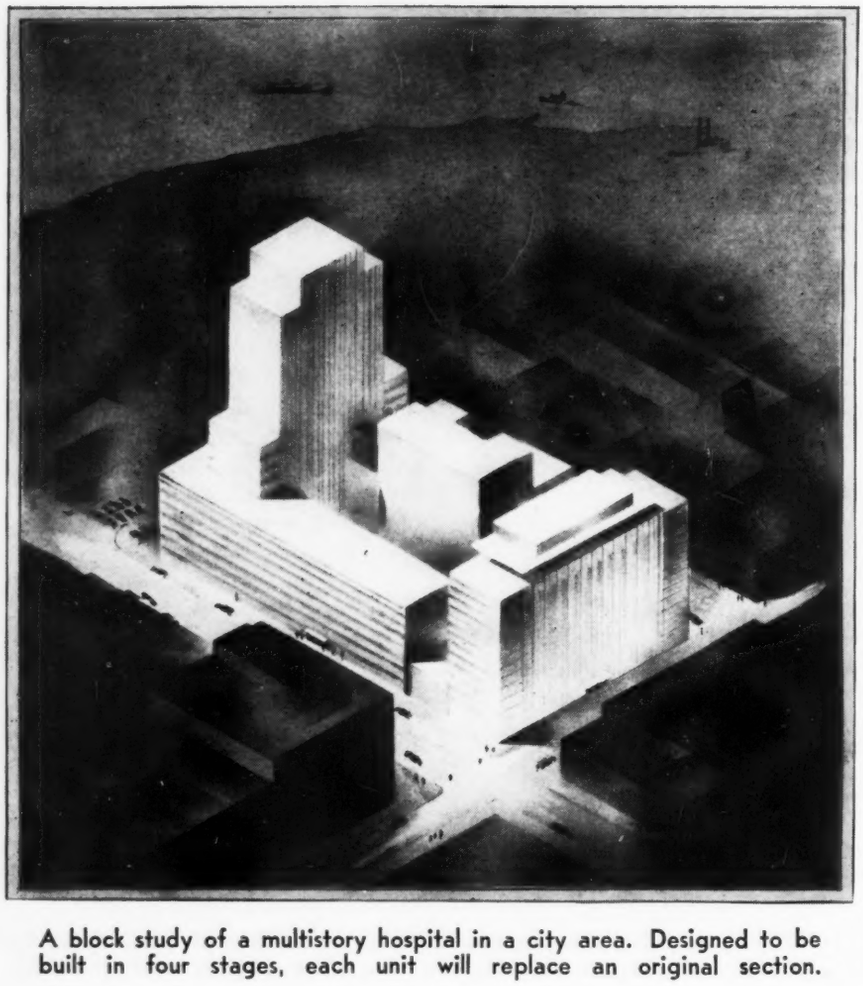
Assistant Administrator, Montefiore Hospital, New York City

WE ARE busy men these days. Nor are we alone in our preoccupations. Clerical and telephone facilities are overtaxed. All of us realize how helpless we are without a good secretary and an efficient telephone. There is no doubt about it, yet we seem to be helpless when callers unreasonably take advantage of the telephone to obtain priority on our time.

The efficiency of a hospital depends in considerable measure on the wise budgeting of the executive's time. Calendars, programs, schedules and appointments are readily unbalanced when someone, either inside or outside of the hospital, takes advantage of the possibility and uses the telephone to escape the necessity of prearrangement. That he may or may not be entitled to the privilege is beside the point. The fact remains that a multiplicity of such unexpected calls may unbalance the whole schedule of our working days.

For example, an out-of-town distributor of supplies is granted an appointment for the following week. He arrives promptly and proceeds with the discussion of his business. As a disturbing coincidence, the bookkeeper decides to straighten out a routine matter which he has neglected for a few days and, finding himself unable to see the executive immediately, calls the administrator on the telephone for guidance while telling himself that his special situation is of an emergency nature. Time is lost without good reason. In fact, more time is lost by the irregular procedure in one way than is gained in another. Incidents of this kind when multiplied can be quite embarrassing.

A well-trained secretary who is a good interceptor and "shock absorber" is one answer to this problem. The common sense rule that there are no rules in an emergency and that, in an emergency, the executive of the hospital may be reached immediately is sound, provided that the internal "public relations" of the hospital has brought about a proper understanding and respect for the term "emergency."



A block study of a multistory hospital in a city area. Designed to be built in four stages, each unit will replace an original section.

The Emphasis is on "PRE"

in Fabrication of Buildings

AARON NATHAN KIFF
Architect
York and Sawyer, New York City

THE most marked trend in all of the construction field over the last two decades has been, and will continue to be, more emphasis on the prefix "pre." Our war production was based on the constant use of this little symbol. Seldom did we find an item of war equipment that originated and finished in the same plant. Parts from here, there and everywhere were assembled at a distant point, as often as not by laborers more or less in ignorance of what they were putting together.

High technical skill on the part of designers, draftsmen and engineers made this possible by thoughtful and careful work on paper before anything, or part of anything, was actually made. The assembling of the atomic bomb illustrates this point perhaps better than anything else but it applied to many war items.

In the building industry also this trend has been going forward. In the prewar hospital many items were prefabricated for later installation in the finished building, and there will be many more in the hospital of the future. Imagination and ingenuity on the part of designers are the only limits to the possibilities.

Any item can be made better and more quickly under ideal conditions in a shop than it can on a construction job. It should also be made at less expense, not because shop labor is less expensive but because more machine methods and mass production procedures can be followed.

Where, in past years, "units of construction" have been prefabricated for the finished building, these units will, in the future, be brought together in "assemblies of units" for installation in the building. Such assemblies as complete bathrooms with all piping assembled and prefitted, pantries, laboratories, windows and spandrels, floor construction and elevator shafts complete with walls, guide rail brackets and hatchway doors are possible. In fact, there is no reason why practically all parts of a building cannot be largely prefabricated, with the exception of the structure itself and parts of it are already prebuilt.

The trend in the basic construction of hospitals will be a further advancement in prefabrication methods. Hospitals will, of course, be of all sizes and shapes but will generally fall into three patterns.

The first of these is the large metropolitan medical center, or hospital, providing service and patient care for, let us say, from 300 to 1500 bed patients and usually providing for nurses' training and teaching of doctors.

The planning of the large hospital in the great cities will be dictated largely by the economic requirements and technological developments, which will determine the type of construction to be used. Most of the larger hospitals are located in the close confines of large cities in which land value is high.

The sites are often bounded by fairly high buildings, which do not provide good exposure for the lower floors. It is common, too, to find that practically all ground available must be used for the lower stories of the proposed hospital, which results in a great amount of enclosed, artificially lighted and air-conditioned space that is not suitable for beds.

Within reason, when more functions can be housed in a single structure, less maintenance will be required and administration will be

simplified. The closer the hospital services are to the beds, particularly in terms of elapsed time in travel, the better the service. This suggests the advantage of speedy vertical travel by elevator over slower locomotion through long corridors of a sprawling building.

All these reasons seem to indicate that the large city hospital will continue its trend toward multiple story buildings with fast elevator service and with the adjunct services on the lower floors and the beds on the upper floors.

In long established existing city hospitals it will often be found that some of the larger of them cover as much as two and three city blocks and that they have used up all the land available to them. Often it becomes almost impossible to continue building on a pavilion basis because the ground simply is not available.

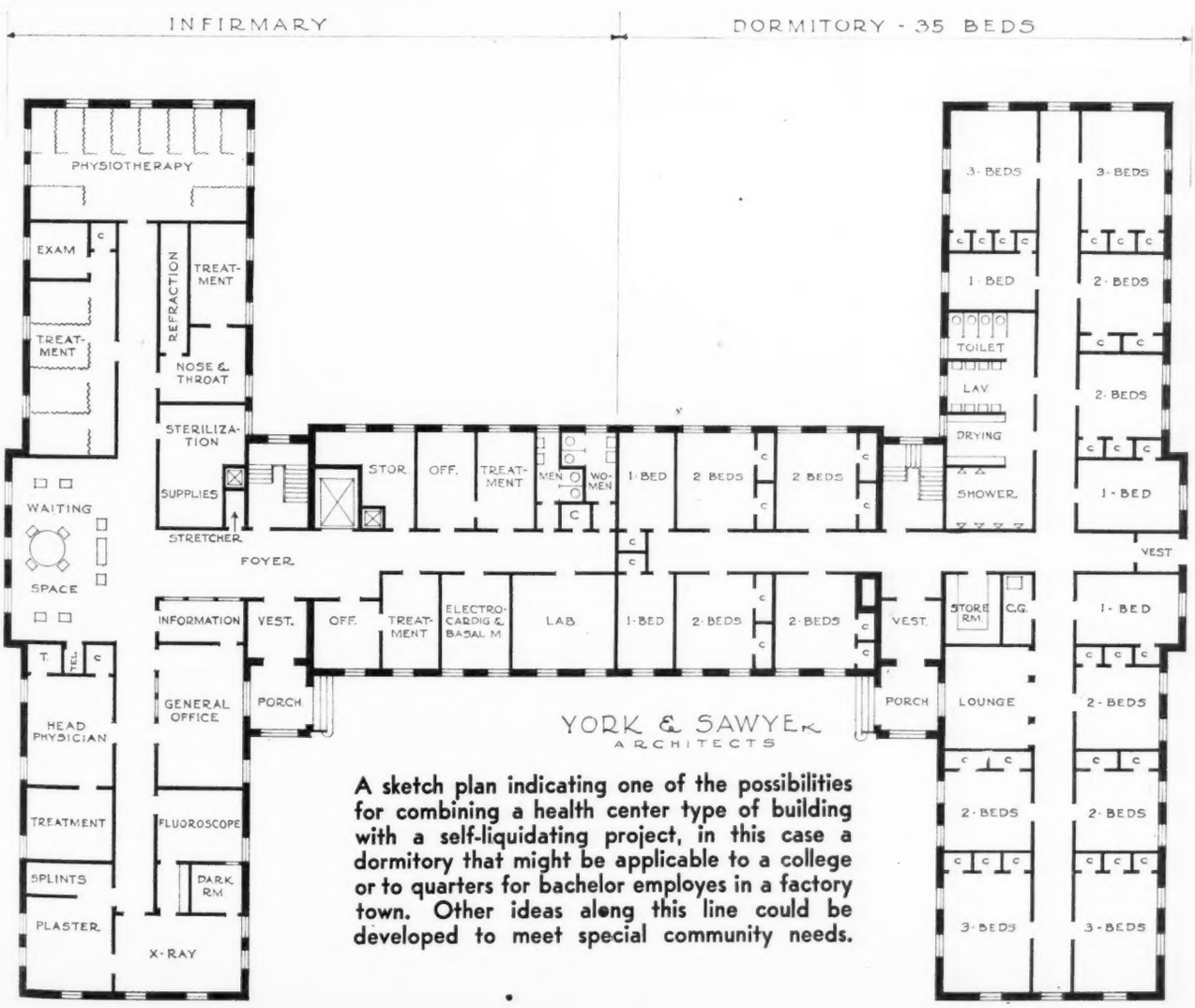
There are many other compelling reasons for multistoried hospitals in the large city, but these will suffice to show that it is not the architects' ideas or new methods that make the trend, nor is it new inventions or ideas of construction.

I believe that these high structures, say six stories and up, will largely continue to make use of the skeleton structural steel frame. All structural steel is prefabricated down to the last detail. All facts are known and tested as to steel calculations used in building construction. The steel design, from its development by the designer through the draftsman, the shop drawings, the checking of shop drawings up to the punching rolls and final fabrication, erection and inspection, leaves little chance for miscalculation and failure.

The final test of steel is its ultimate strength after being built in and its longevity. The recent accident of a B-25 flying into the Empire State Building broadside at the seventy-ninth floor bears out this statement. The damage to the steel by this impact was minor and localized to a few beams out of hundreds of tons of steel.

Concrete will, in certain areas, be used as in the past, but when city hospitals get much beyond six stories, there is no apparent reason to assume that the concrete frame will be used to a great extent. It brings into the operation much more of the human element as concerns design and construction and, therefore, more chances of poor results. It will also generally result in a larger cross-section area of the columns in the lower stories, with a loss of space and flexibility.

A recently built hospital of 10 stories, of concrete design, required the use of structural steel cores as reenforcement for the lower story in order to cut down the excessive size of the columns. This is not meant to imply that concrete should not be used for higher buildings, if some compelling reasons make it desirable. What is implied is that, when the steel and concrete are equally available, the steel design for a multiple story structure is less subject to human failure and is more adaptable to



A sketch plan indicating one of the possibilities for combining a health center type of building with a self-liquidating project, in this case a dormitory that might be applicable to a college or to quarters for bachelor employes in a factory town. Other ideas along this line could be developed to meet special community needs.

confined city building operations.

The steel will be delivered as needed and can be erected directly from the trucks on which it is delivered. A definite trend in connection with the use of the structural steel frame is the impetus which has been given to welding by the war.

The second general type of hospital will be the smaller urban hospital of from, say, 100 to 300 beds, located in centers of population serving considerable areas in the surrounding countryside.

The reasons for multiple story construction of hospitals of this size are functional rather than exclusively economic. A hospital of from 200 to 300 beds will be better planned if it is vertical instead of horizontal. A 200 bed hospital is a sizable institution, even with a minimum of other services or specialty functions. If we assume a plan with two services to a floor, four or five stories are needed for beds alone. Allow two floors for other necessary functions and we have a single building scheme of six or seven stories.

In these smaller urban centers I believe that wall sections of less thickness than the 12 inch masonry wall will be seen before they become common in the larger centers. Code requirements will be based more on the responsibility of the architect and builder than on set regulations, as is true in the large cities in which building departments "get set," and it takes an act of God to change anything.

In existing hospitals in these smaller urban centers, some way should be worked out to make it possible for the overcrowded hospital somehow to get rid of its original 1895 to 1915 building. This structure was built when the institution was founded to house perhaps 50 to 100 beds. With the growth of hospital service, it has been added to and added to until the tail is wagging the dog, with the original 50 to 100 beds being practically at the front door of the building, stymying any effort to coordinate the plan as a whole.

These original high story, masonry-bearing wall structures seem always to make additions possible only by compromising the plan. They have given their best service and have earned their retirement; somehow they must be replaced so that the hub of the plant can be revitalized and again be the newest and most modern part of the hospital and not the most outmoded. The state and federal hospital aid that seems to be coming may make it possible for hospital trustees to get rid of these antiques and save some expensive maintenance and difficult management.

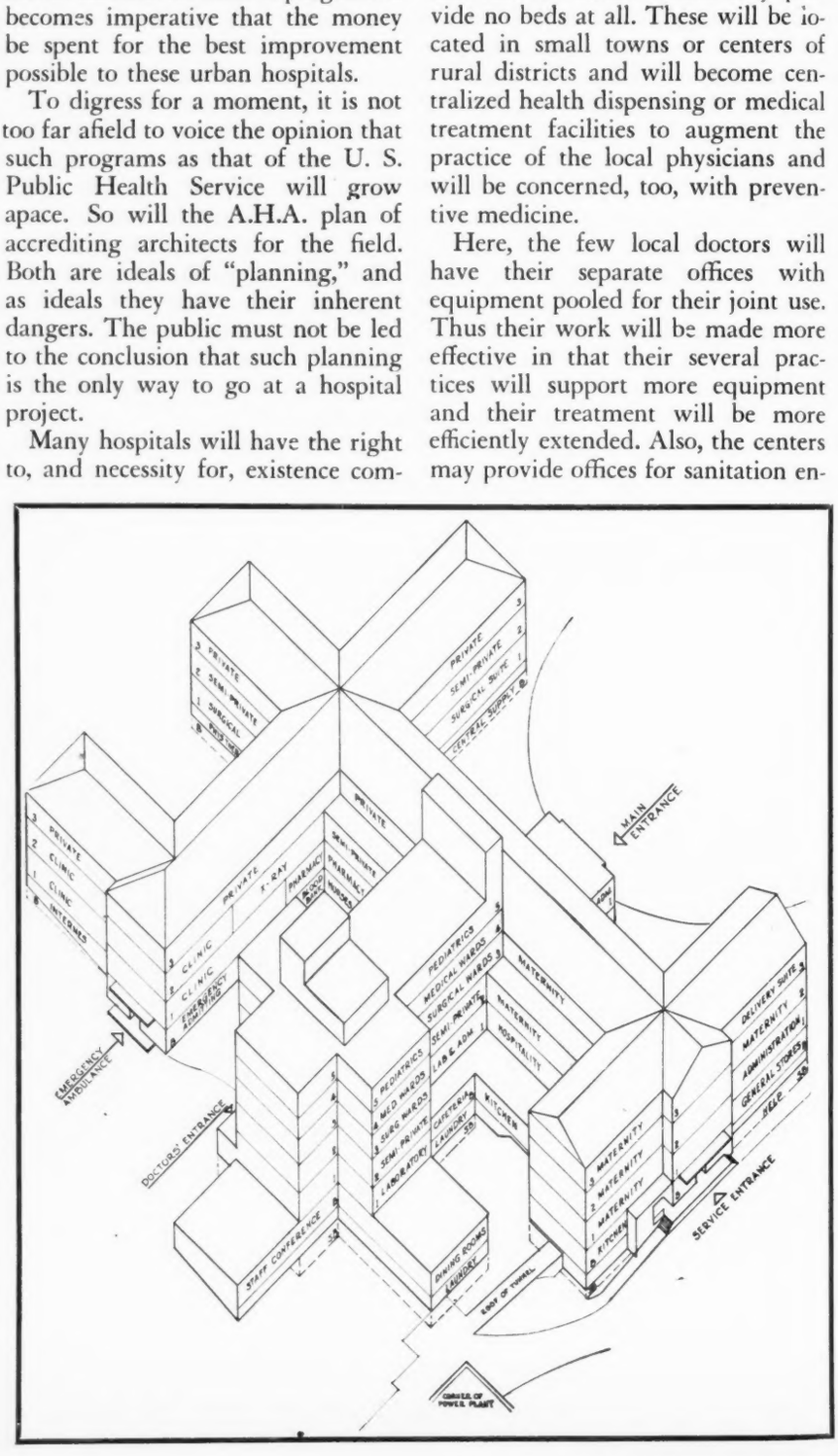
The announced program of the U.S. Public Health Service, through its Hospital Facilities Section, seems to point the way for such a development and, indeed, if public funds are to be used in such a program it becomes imperative that the money be spent for the best improvement possible to these urban hospitals.

To digress for a moment, it is not too far afield to voice the opinion that such programs as that of the U. S. Public Health Service will grow apace. So will the A.H.A. plan of accrediting architects for the field. Both are ideals of "planning," and as ideals they have their inherent dangers. The public must not be led to the conclusion that such planning is the only way to go at a hospital project.

Many hospitals will have the right to, and necessity for, existence completely outside the scope of the coordinated program outlined by the U. S. Public Health Service, and encouragement should be given such hospitals to go their individual way. Also, there will be many well-qualified architects outside the fold of the A.H.A. accredited list, as there will be some qualified but incompetent architects on it. There is no such thing as perfection, which is no reason for not striving.

The third type of hospital is the institution of under 100 beds and the rural health center which may provide no beds at all. These will be located in small towns or centers of rural districts and will become centralized health dispensing or medical treatment facilities to augment the practice of the local physicians and will be concerned, too, with preventive medicine.

Here, the few local doctors will have their separate offices with equipment pooled for their joint use. Thus their work will be made more effective in that their several practices will support more equipment and their treatment will be more efficiently extended. Also, the centers may provide offices for sanitation en-

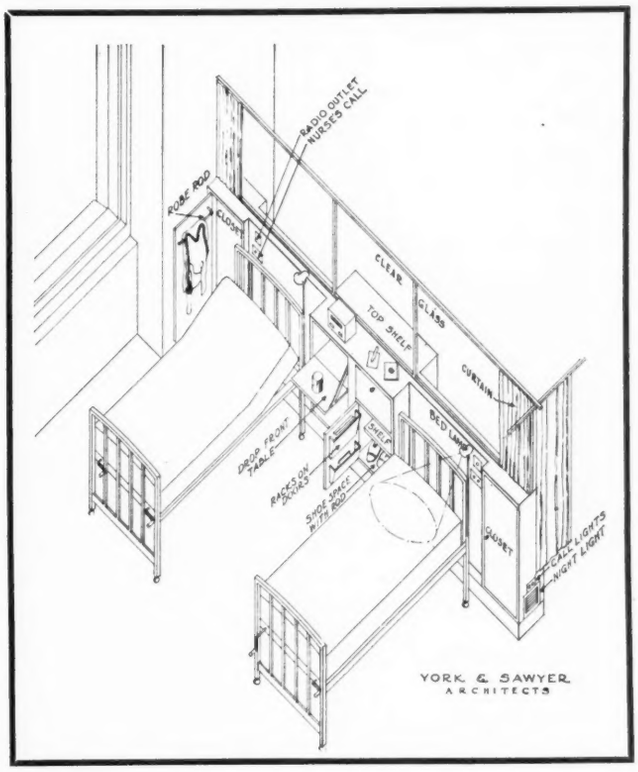


gineers and other related municipal services as, for instance, the board of health.

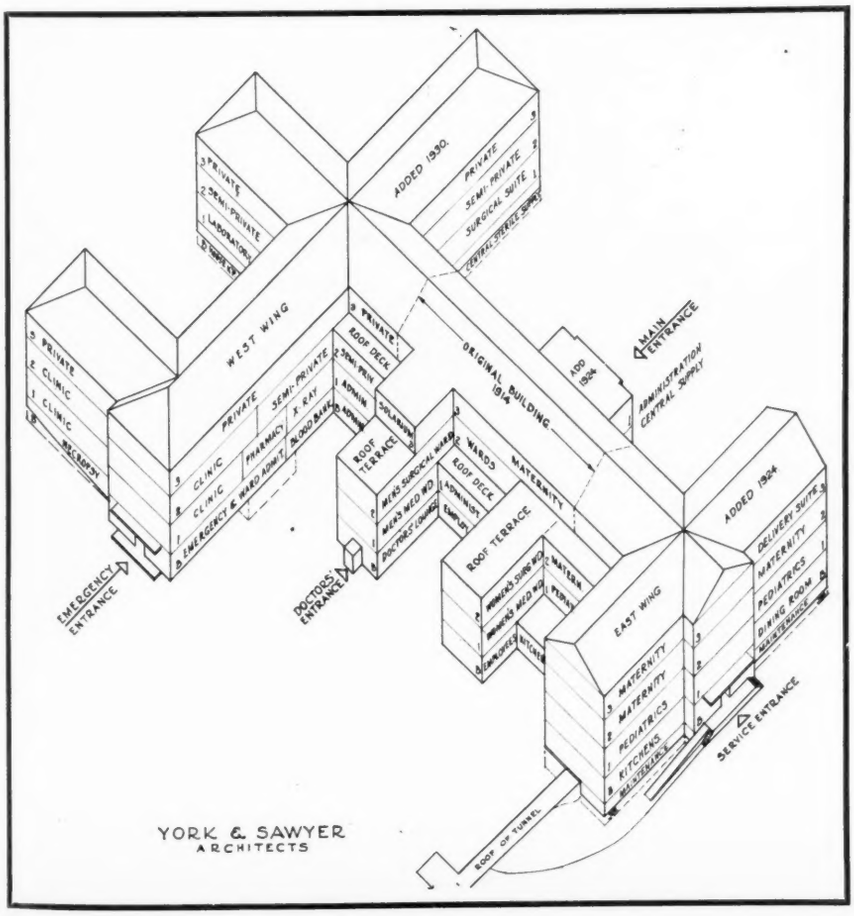
These health centers may well be financed by the local municipality or by grants from the states; or, as in the case of one project in which our office is now engaged, by the industry of the town to the betterment of its employes' health. What often looks like altruism is not always disinterested, and it is recommended that chamber of commerce leaders in any town of 5000 population supported by one, two or three plants have a talk with the owners of the industries.

A grant of perhaps $50,000 from each plant would pay far greater dividends to the plant owners than does some of the stuff that they hire publicity and advertising agents, at higher annual costs, to get off in the name of public relations.

The health centers will be constructed of any and all materials, depending only on local conditions and the availability of materials. Since, generally, they will operate on a non-resident basis and have no beds, there is usually no reason why they should be more than fire-resistant buildings. They will be of one or two stories.



Right: A cubicle partition for use in wards laid out on the Copenhagen basis, as developed in an Army hospital. All necessary bedside functions are incorporated in this prefabricated unit. It may be constructed of wood or metal. Below: The two isometric drawings illustrate a 350 bed hospital that has outgrown the original plant. They show how, by the abandonment of the two wings just opposite the entrance, it becomes possible to recentralize the hospital function. The drawing on the right is the hospital as it now stands; on the opposite page, the improvement that could be made.



As these health center buildings will serve their purpose if they provide for a generation of doctors, it might be well if they are so constructed that the new generation of staff men will be able to rebuild them to accommodate new equipment and changing methods of practice. Our developing asbestos, wood impregnating and light metal industries might, in this type of structure, find an outlet for their products.

The rural health center that is combined with a hospital of up to 50 beds presents much the same picture as the health center, with the added incentive to the doctor that his obstetrical and simpler cases can continue under his care while hospitalized. Here, again, a public-spirited industry could afford to endow and possibly build the institution.

The construction to be used in these three types of hospitals will differ greatly, and the "trend" in their construction will be dictated not by the planning tricks involved but by the economic and technological advancements at the disposal of the architects and builders. The architect's greatest satisfaction should lie in analyzing and planning his design and in so crystallizing it as to correlation of details and construction that the work of the engineers and contractors results in a building as nearly perfect as it can be made.

So You Meet Minimum Standards

But What About the *Maximum?*

FLORENCE KING
Administrator, Jewish Hospital, St. Louis

ONCE a year our newspapers publish the names of hospitals in our community that have been approved by the American College of Surgeons. We glance down the list, ascertain that our own hospital is included, pat ourselves on the back and thank heaven that we've made the grade another year.

If we pursue the matter further, we concede that the college did a magnificent job back in 1918 when it established the minimum standards and we congratulate ourselves on toeing the mark as far as organized medical staff, regular staff meetings, by-laws, medical records and diagnostic and therapeutic facilities are concerned.

The Idea Was to Forge Ahead

Only a fool would dispute the fact that with the establishment of the minimum standards many of our hospitals were yanked up by the boot straps and given a veritable twinge of professional conscience. But only a fool would say that the college anticipated that hospitals would be content with the minimum and not seek to achieve the maximum in standards. Given the impetus of the college's pioneering, it surely was expected that our hospitals would seek continual improvement.

Today's hospital administrator must stop rocking back contentedly in his swivel chair and gazing complacently at the framed copy of the minimum standards hung in his office. He had better sit bolt upright and think beyond to a future of maximum standards if he truly wants to show his appreciation of the stimulus given hospital administration when the minimum standards came into being.

From an address given at the sectional meeting of the American College of Surgeons, St. Louis, 1946.

All inclusive as they are, there is much in hospital administration that these minimum standards do not embrace. Designed to cover the utmost in excellent professional care to the patient, there is implied but not direct mention of a high concept of such aspects of hospital administration as finances, personnel management and that humanitarian spirit which should be the hospital's primary consideration.

We are inclined to make sweeping statements about the patient being of prime importance, but in this respect are we honest? Let me challenge you to pick up almost any hospital's monthly or annual report. What will you find on the first page? *Receipts and Disbursements.* An inquiry to any of us about the year's work usually elicits a long dissertation on deficit or profit, as the case may be. Not until we have sated our hearer with the last vestige of financial gloating, do we belatedly mention the fact that, yes, we did take care of more patients than during the preceding year.

If hospital administrators place finances ahead of patients, how in the name of common sense can we imbue our personnel with the idea that the patient should always come first?

We shake our heads and click our tongues over the discouraging fact that some of our hospital personnel are not considerate of the patient; indeed, that occasionally they are rude and lacking in understanding. But don't they take their cue from the administrator? If he eats, sleeps and breathes dollars and cents, can he expect his employes to have a different philosophy? Can the hospital administrator who boasts that as soon as a patient's funds run low he summons an ambulance and transfers him to a city institution expect his employes to effervesce with compassion for the patient?

Can the hospital that admits to its free service only those patients who are interesting from a scientific point of view expect to train doctors and nurses who have high humanitarian standards and a keen social conscience? Far be it from me to disparage the value of good clinical material for teaching purposes. Yet I must decry the oft-times current vogue of screening out a seriously ill patient just because he presents no startling clinical findings.

Second in importance to high standards for patient care come high standards for personnel management. We prate of personnel practices and, because of war-time exigencies and industrial competition, we are at last giving some thought to salaries, vacations and sick leaves. But how many of us can proudly exhibit to any visitor the restrooms and recreational facilities provided for our employes, particularly those in the lower brackets?

We're Still Talking About Them

During the past year or two we've waxed loquacious on the subject of pensions for our personnel, but with few exceptions this has amounted only to a massive dosage of wishful thinking. As they say down South, we're "a-fixin'" to do something about it but for most of us it's just a case of *mañana.*

And what about employe records? Industry has shown us up during the war. Who hasn't received an inquiry about a former employe and found, to his chagrin, no card for him or too scant information to be of value in assisting him to obtain more gainful occupation?

Recently, when I requested references for a nurse from a hospital that boasts about its ideal personnel practices, I received this nonchalant reply: "Oh, people come and go so fast, we just can't keep track of them." One of our resident staff faces the possibility of being denied that financial assistance which is now offered veterans by the government because a hospital in which he interned five years ago has no record of his terminating his internship to enter military service. Can such carelessness in the hospital's policies breed anything but carelessness in its employes?

We all look smug and cocksure

when recounting how meticulous we are about doing complete "physicals" on all our employes. However, I'd wager that this standard has in many cases become a war-time casualty that we must revive *stat.* The hospital, of all organizations, should have been the first to cleave to high standards of employe health but, again, it has allowed industry to beat it to the draw. Yes, I realize that Uncle Sam and industry lured our nurses and doctors from us and left us so short of personnel that we had to compromise and make short cuts. But does that prevent our taking stock now and determining to mend our ways as soon as we can again have a corporal's guard of nurses and doctors?

War-time adversities of necessity forced many an administrator to abrogate and curtail, but they also afforded him an opportunity to prove his mettle. If he strove to carry on in the best tradition and bowed only to the inevitable in making concessions, he has not failed his hospital. If he shrugged his shoulders and used *"c'est le guerre"* as an alibi for permitting inexcusably haphazard habits to creep into his hospital, he has proved himself a renegade administrator.

But the war is over. Sins of retrogression or stagnation may be forgiven and forgotten now if we are determined to be satisfied with nothing short of progression. And the avenues of progression are legion.

Some Ways to Make Progress

Let me enumerate some of the other fields in which the hospital administrator can seek high standards. If he envisages progress for his institution, he must include in his program: further education and training for himself and his personnel; enlargement of the scope of his hospital's service by establishing special clinics, such as well baby, prenatal and postnatal; instituting preventive, diagnostic and therapeutic programs in such fields as tuberculosis and cancer; accelerating the hospital's public health and community activities by insinuating himself and his entire institution into the whole community picture.

Too many of us have professed faith in high standards and then have proceeded to let things slide to a literal minimum. For some of us, standards have simulated a cross-stitched sampler hung high upon the parlor wall. We've subscribed to the embroidered motto but we've been downright snide and slipshod in our ways. It's time we got back to our mothers' homily that what's worth doing at all is worth doing well.

If the administrator wants high standards to prevail in his hospital, he had better take his eyes off the valley of the minimum and focus his vision on the mountain peak of maximum standards for the hospital of tomorrow.

New Venture in Nurse Education

NATHANIEL W. FAXON, M.D.

Director, Massachusetts General Hospital, Boston

A NEW coordinated plan for the training of selected young women who expect to make nursing their profession will be offered in September by Radcliffe College in cooperation with the Massachusetts General Hospital School of Nursing. This program has been evolved as a result of the conviction of the governing boards of both institutions that the profession of nursing increasingly requires women with a broad educational background.

Students entering the program will carry full work at Radcliffe College for their first year and, in addition, will spend three hours a week at Massachusetts General Hospital. The first summer session of six weeks will be at the school of nursing. During the next two and a half years, including summer sessions, instruction will be given both at the college and at the school of nursing. At the end of the three and a half years the student will receive her bachelor's degree from Radcliffe College. She will then spend two full years in the school of nursing after which she will receive her diploma.

Students enrolled in this program may choose fully among the 29 undergraduate fields of concentration offered by Radcliffe College and will complete all requirements for the Radcliffe A.B. or S.B. degree.

No preprofessional courses will be included in the college program that might in any way limit the breadth of general education and no college credit will be granted for work taken in the school of nursing. In order to adjust the classes with preclinical sciences to the college schedule and to provide instruction adapted to the needs of the college students, separate courses will be offered in the school of nursing for these students in addition to the courses now provided for the three year basic program.

The coordinated plan will be administered jointly by a committee of trustees and a committee of faculty from the two institutions.

Applications for entrance will be made to the college but they will be acted upon by a joint admissions committee from the two institutions.

Will Pay Tuition Fee

During the college years the student will pay the regular fees to the college. Tuition and fees for the nursing school during the entire five and a half years total approximately $500. The trustees of Massachusetts General Hospital will offer a limited number of scholarships to applicants and enrolled students who qualify for financial aid. Students will also be eligible for assistance from the Radcliffe College scholarship funds.

For the first three and a half years, students will live at the college and enjoy the privileges of that student body. The first summer session and the two final years students will live at the school of nursing and participate fully in the life of the school and hospital.

It is the hope of both the college and the school of nursing that through the intermeshing of the two programs the stimulus of a professional goal may give added purpose to the liberal arts and the breadth of the liberal arts may develop greater awareness of the opportunities and obligations of the profession of nursing.

Methods of Measuring the *Quality* of Nursing Care

KEITH O. TAYLOR
Assistant Administrator, Peralta Hospital, Oakland, Calif.

STANDARDS of nursing care have been carefully established; the number of nurses needed to care for a given number of patients has been estimated and classified according to the type of patient to be cared for, whether medical, surgical, obstetric or pediatric. However, no standard method of determining how well the nursing staff functions has been established.

A hospital may meet standard ratios of the number of nurses to patients, or nursing hours to patient days, but quantitative sufficiency does not in itself assure qualitative adequacy. Any attempt to determine the real adequacy of a nursing service is dependent on knowing how much the nurse as an individual and nurses as a functional group can do and do well.

Must Record Work of Nurses

An analysis of adequate nursing service, therefore, calls for some means of studying and recording the actual work of the floor duty nurses, of noting errors and weaknesses in administration, as well as factors that appear to contribute to a satisfactory and well-organized service. Such analysis also requires means of synthesizing the findings of the study into a portrayal of the quality and adequacy of ward nursing for administrative use.

Condensed from master's thesis prepared for the University of Chicago hospital administration course.

In a general way, evaluation of the adequacy of a nursing service can be made through the use of quantitative measurements: the ratio of hours of nursing service to patient days and the proportion of graduate to student nurses. These figures can then be compared with standard ratios, such as those established by the American College of Surgeons and the joint committee of the American Hospital Association and the National League of Nursing Education.

Quantitative methods, however, afford only a partial measure of the adequacy of a nursing service; they leave many of the more important questions unanswered. In an attempt to achieve some technic by which qualitative aspects of nursing service might be measured, the first step is to define the factors that would be important from an administrative standpoint and classify them as far as possible.

Two groups of factors appear essential to the successful functioning of the nursing department. In the first place, there must be proper organization, with adequate supervision and coordination of activities, definite and reasonable assignment of duties, and economy of both material and personnel. In the second place, there must be high standards of individual nursing care. These individual standards embrace the manual skill, observation and proper recording and, finally, the personal qualifications of the individual nurse.

Under manual skill are grouped the many nursing duties that comprise the regular nursing day, *i.e.* medications and treatments, baths and back care, bedmaking and irrigations. Observation and recording include the careful notation of the patient's condition and changes as they occur and the clear, concise recording of important and relevant facts.

The factors that make up the personal qualifications of the nurse are somewhat less tangible but are manifest in the nurse's attitude toward patients, doctors, supervisors and fellow workers, in her adjustment to her duties and her grasp of situations.

Question Is "How Well?"

The ratio of nursing hours per patient or the ratio of supervisors to bedside nurses can only answer the question, "How much?" Some methods of answering "How well?" are in general use, however, and a few of these should be considered. One such method is a report by the head nurse as to the operation of her division. This may be a written report or, more often, a verbal report to the supervisor. In any event, it is limited in scope and based on a necessarily brief view of a busy section of the hospital. It is true that the head nurse is on her floor for a considerable portion of each day, but her other duties are too many and too arduous to permit a careful survey of the quality of floor nursing.

Since supervisors' reports are based in part on information provided by the head nurse, their reports, which provide a second source of material on the quality of nursing, will carry over the weaknesses of the head nurse's reports. Moreover, the scope of the supervisor's responsibility extends over several divisions and leaves her but little time for careful observation of individual nursing. Much of her time is concerned with personnel problems and schedules that must be handled in the nursing office.

The amount of her administrative training varies, but it is usually secondary to her experience in general duty nursing and head nursing. Her reports are important but inadequate as a sound basis for judg-

ing the quality of the nursing service as a whole.

"Unusual occurrence reports" offer another source of information regarding the quality of nursing service. Figure 1 shows a typical report form. These reports provide the administration with a means of checking on the occurrence of errors or accidents and prove extremely useful if conscientiously followed up by head nurses. The weakness of such reports lies in the fact that each one is usually considered separately and then filed away. But when, instead, unusual occurrence reports are accumulated and summarized, an analysis of the incidence and frequency of errors and accidents is provided.

In general, however, present methods of judging the adequacy of nursing service are limited. Quantitative ratios fail to give an index of quality, and the qualitative reports in common use are likely to be based on inadequate data and are limited in scope.

Emphasis on Timing

Special studies have been undertaken from time to time; for example, the Bellevue Hospital study conducted by Pfefferkorn and Rottman[1] brought out many interesting technics. Considerable emphasis was placed on timing individual procedures, and though these timings had value they were not of great help in determining quality. Moreover, this study required expensive methods, involving a sizable group of investigators; thus it does not have wide applicability.

The problems involved in a study of nursing are complicated by the individuality of patients. For this reason, the timing of duties must take into account the patient's condition and personality, as well as the skill of the nurse. The measurement of the adequacy of nursing service is not so simple as that of a laborer working at a machine.

To be successful, the nurse must adapt her procedures to the individual patient and the individual situation. Her success may be gauged, in the final analysis, though seldom with exact nicety, by the physical recovery and mental equanimity of the patients under her care. The manner of her approach, the carefulness of her observation and the adaptation of her art and skill to each patient afford the real measure of her qualifications as a nurse.

Although these factors differ in tangibility and in some cases defy exactness of measurement, they must all be considered in summing up the quality of nursing service. Together with the organization of the department, the availability of supplies with which to work and the extent and kind of supervision provided, they offer an answer to at least part of the question, "How adequate is the nursing service?"

After a study of nursing literature, conferences with nursing superintendents and administrators and preliminary direct observation, six factors were chosen for consideration in developing the technics of measurement:

1. The amount of nursing care provided patients.
2. The amount of supervision provided for general duty nurses.
3. Organization of the nurses' day.
4. The provision of proper facilities and equipment for the nurses.
5. The quality of nursing care.
6. The quality of supervision.

Not all these factors were, or could be, measured directly, but even when an indirect approach was required the results contributed to the final analysis.

Fig. 1—Report of Unusual Occurrence

Date..... Hour.....

Patient's Name .....

Room..... Physician.....

State clearly and concisely just what occurred:

.....Nurse

Resident Physician's Statement

.....M.D.

Supervisor's Statement

.....Supervisor

.....Supt. Nurses

Fig. 2—Sample Study Sheet

Name..... Date.....

Ward..... Case Load.....

Duty	Began	Ended	Elapsed	Notes
Charting	9:02 a.m.	9:10 a.m.	8 min.	Student makes adequate charts
Bath	10:00 a.m.	10:16 a.m.	16 min.	Time wasted because supplies were not conveniently arranged

[1] Pfefferkorn, Blanche, and Rottman, Marian, Clinical Education in Nursing. New York: The Macmillan Company, 1936.

Technics for quantitative measurements of the amount of nursing service and the amount of supervision were already at hand, and these were adopted. The ratios thus obtained provided a basis for comparing the amount of nursing in a hospital under study with averages derived from a selected group of other hospitals. Such comparison was possible in only one of the studies described here, however, as the second study occurred in a hospital for chronic diseases, a type for which no reliable base data have been established.

In the general hospital, Hospital A, where studies were made on one medical and one surgical ward, the ratio of nursing hours per patient in the medical division was somewhat under the averages established by the American College of Surgeons and those given in the studies of Rovetta and Pfefferkorn.[2] The surgical division provided more than the average number of nursing hours per patient, but the percentage of student hours was high.

Lower Ratio of Nursing Hours

The two wards in Hospital A, therefore, showed a somewhat lower ratio of nursing care hours than the standards, the medical ward with half an hour less nursing service per patient than the standards given by Rovetta and Pfefferkorn and the surgical ward with a much smaller percentage of graduate staff to students than that stated by the same authors.

On the basis of this type of comparison, it might be reasonable to suppose that the nursing service in Hospital A would be somewhat below that in hospitals with a higher ratio of nursing hours per patient.

The difficulties encountered at this point are those common to any comparison based on purely quantitative measurement. How good was the nursing service at the hospitals with a standard ratio of nursing hours on their medical wards, and what were the inadequacies of Hospital A's own service? Would the use of an additional half hour of nursing service bring improvement in line with the additional cost of nursing?

Was the service actually less adequate than in hospitals with a higher ratio, or was it equal because it was also more efficient? None of these questions could be answered by reference to the quantitative ratios; it was in search of these answers that other technics of measurement were sought.

It was apparent from the beginning that any successful methods would need to be based largely on direct observation of floor nursing. Four factors in addition to the quantitative ratios remained for study, all of which could best be answered by actual observation under working conditions. The four factors were organization of the nurse day, the provision of proper facilities and equipment for the nurses' work, the quality of nursing care and the quality of supervision.

Time studies alone could not provide a full measure of the desired information. They were essential to provide a picture of the nursing day and a record of delays caused by improper facilities and equipment, but they would not provide measurement of the quality of the nursing and supervision, although these were the more important aspects of the problem.

Preliminary observation of the wards, demonstrations of proper nursing technics and a study of nursing procedures were the basis of a time and analysis study which was then prepared. The sheet adopted for the gathering of information is illustrated in figure 2. The heading provided room for the nurse's name, the division, the nurse's case load and the date.

The sheet was then ruled off in five columns. Column 1 at the extreme left edge carried the heading "Duty." No preconceived classification of duties was made, in order that each operation would be recorded on the basis of direct observation. There is thus no need to fit an observed situation into a set scheme and limit the freedom of the observer's thought or style. Although this results in somewhat more work on the summary, it is justified by the flexibility of the method.

The second and third columns show the time duties began and the time they ended; this information was recorded for each corresponding entry of a duty in the left-hand column.

Timings were made with a regular watch rather than a stop watch, since it was felt that little information could be derived from split-second timing of nursing duties, which are not routine, precision tasks. In special cases, stop-watch timing of a few procedures can be used in supplementary studies. The elapsed time, column 4, was entered at the end of the observation period by simply subtracting the time recorded in column 2 from that in column 3.

Column 5, at the extreme right, provided room for essential notes which could be used to indicate any item concerned with the quality of nursing or supervision, organization of work or availability of supplies. The use of such notes is limited only by the experience of the observer and the care with which observations are made. Sufficient room must be allowed for all such notes as the observer may wish to record.

Brief Notes Sufficient

In these studies, however, it was found that brief descriptive notes were generally ample to recall the incident in full. Much of the strength or weakness of the entire study depends on the proper use of these observational notes and the objective reporting of incidents that occur. These notes proved of value to the nursing service in calculating need of supervision and weak points in availability of supplies.

The summary of the time studies (table 1) provides a picture of the average nurse day and the amount of time spent in various types of duties. This is valuable not only to gauge the extent to which organizational plans are being carried out but also to point out changes that may be effected. In a hospital, where nonprofessional duties claim an undue percentage of nursing time, the employment of additional aides to take over these tasks may well increase nursing effectiveness and result in an economy for the department.

The time summary may also be used in connection with the summary of special notes to indicate possible misuse of time, as in the case of charting at Hospital A, where notes were found to be inadequate, although a considerable amount of time was spent by the nurse in their preparation.

[2] Rovetta, Charles A., and Pfefferkorn, Blanche, Administrative Cost Analysis for Nursing Services and Nursing Education. Chicago: American Hospital Association and National League of Nursing Education, 1940.

TABLE 1—Summary of Nursing Activities—Hospital A

Duty	Time Spent (in Minutes)									Total	Average
Nurse	A	B	C	D	E	F	G	H	I	All	All
Conference with supervisors	28	40-	15	20	16	37	10	15	15	196	21.7
Charting	34	24	38	24	45	16	19	20	25	245	27.2
Rounds with doctors	18	..	15-	7	..	30	30	..	..	100	11.1
Group A Duties (1)											
Baths	24	..	5	..	..	..	16	23	16	84	9.3*
Medications	3	47	12	3	19	4	11	4	24	127	14.1
Dressings, binders	30	4	16	30	..	2	..	5	..	87	9.6
Special treatments, irrigations	..	16	..	2	14	15	21	19	7	94	10.4
Compresses	16	..	..	..	..	60	..	..	..	76	8.4
Preparation for surgery	15	..	..	..	..	..	..	..	..	15	1.6
Ice bags and hot water bottles	..	..	..	..	11	4	..	2	..	17	1.8
Temperatures	7	23	8	12	15	8	14	5	10	102	11.3
Enemas	..	..	13	..	30	..	..	11	..	54	6.0
Make patient comfortable	..	16	..	17	12	3	..	24	10	82	9.1
Total Group A	95	106	54	64	101	96	62	93	67	738	82.0
Group B Duties (2)											
Make beds	29	..	31	24	12	10	16	21	17	160	17.7a
Trays	5	75	20	13	14	10	30	16	37	220	24.4
Admit and discharge patients	..	..	13	..	..	..	..	..	..	13	1.4
Move patients—assist ambulatory	..	31	..	14	5	18	..	8	..	76	8.4
Sterilizing	..	..	..	..	13	..	..	..	..	13	1.4
Total—Group B	34	106	64	51	44	38	46	45	54	482	53.5
Group C Duties (3)											
Strip beds, make empty beds	8	7	5	2	6	..	3	..	6	37	4.1
Clean bedside stands, remove basins, soiled linen	5	..	8	3	8	..	23	19	25	91	10.1
Bedpans and urinals	8	7	3	..	11	5	3	1	..	38	4.2
Fix flowers	2	..	..	..	..	7	..	7	2	29	3.2
Look for dressing carriage, supplies	3	..	8	5	..	..	..	..	..	16	1.7
Telephones, messenger service	..	..	..	1	..	..	..	1	44	46	5.1
Total—Group C	26	14	24	22	25	12	29	28	77	257	28.5
Other a.m. care not observed	65	82	83	49	120	58	82	94	70	703	78.1
TOTAL TIME	300	372	293	237	351	287	278	295	308	2721	224.2

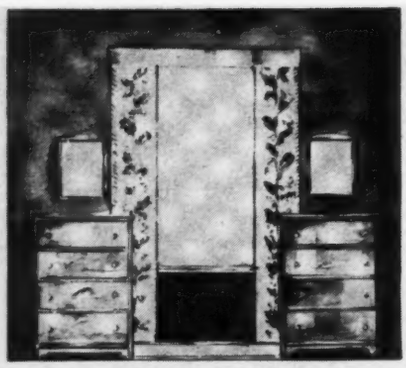
(1) Primarily professional. (2) Semiprofessional. *Average time for 8 baths was 10.5 minutes.
(3) Nonprofessional. aAverage time for 19 beds was 8.4 minutes.

The final technic employed was a summary of unusual occurrence reports. Errors and accidents occurring with the greatest frequency were tabulated by the month for a year's time. This method permitted an analysis of the monthly increase or decrease in any specific category. Subsequently, a monthly tabulation of this sort has been maintained, so that the administrator may have a continuous report of these occurrences and the effectiveness of changes in supervision designed to reduce or eliminate them.

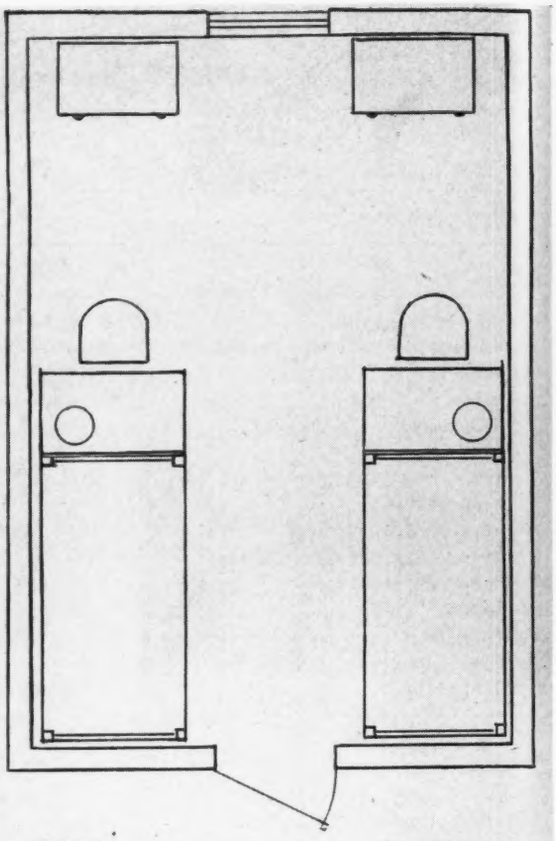
It is apparent from the results of these studies that better sampling might have been possible with the employment of more than one investigator and additional time in which to work. An increased number of time studies would allow for comparison between divisions, and with these data separate summaries for each type of work in the general hospital could be made.

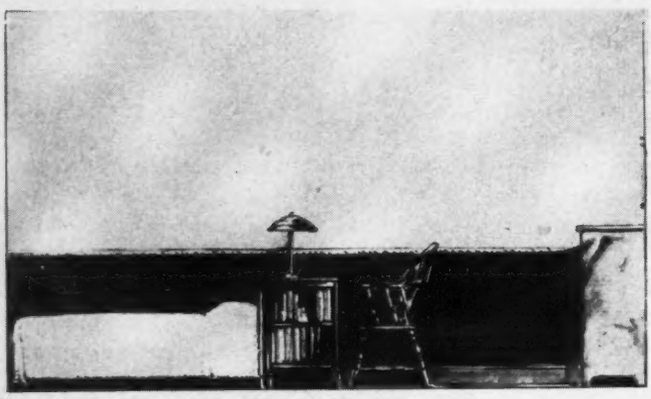
It is important to note, however, that a considerable body of material can be worked up by one observer in a relatively short time. Reports based on these technics cannot answer all questions that might be asked in regard to a nursing service, but they do answer many and suggest an approach to others.

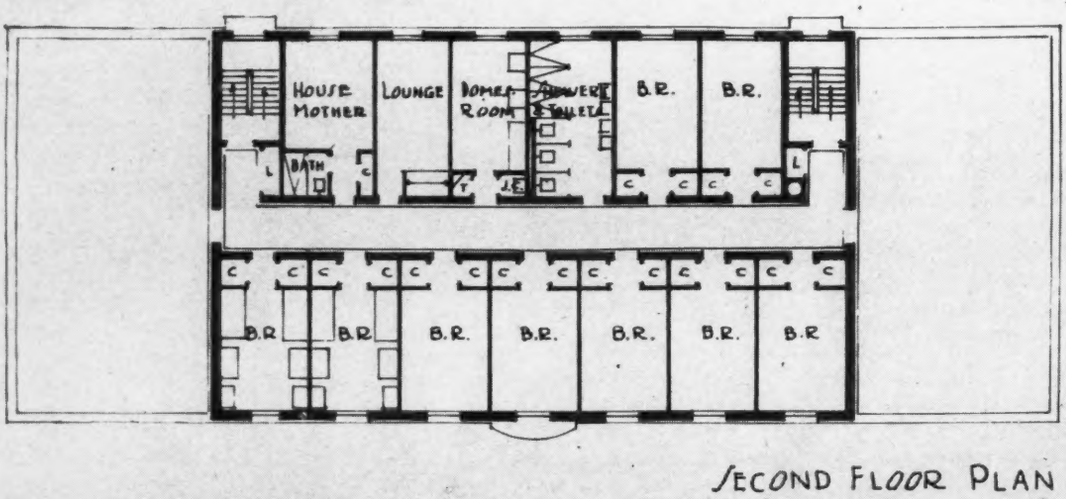
This is the first of a series of three articles by Mr. Taylor on the adequacy of nursing service. The second article will appear next month.—Ed.



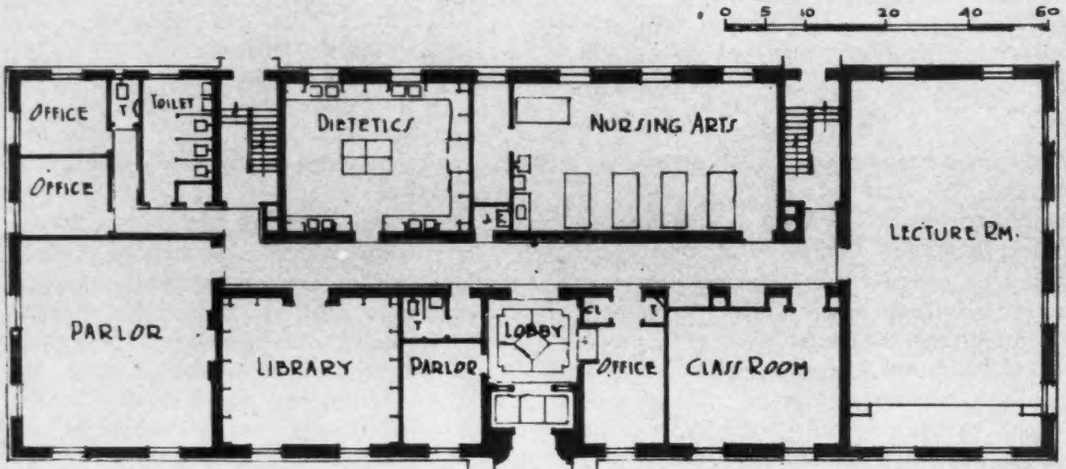
NURSES' HOME
MASSILLON
CITY HOSPITAL
MASSILLON, OHIO







SECOND FLOOR PLAN
0 5 10 20 40 60



ALBRECHT & WILHELM
ARCHITECTS MASSILLON·O.

FIRST FLOOR PLAN
0 5 10 20 40 60

Floor plans and room layouts of the nurses' home. The building has accommodations for 40 students and a house mother; recreation room, and classroom facilities. The drawings at the top of the page show the arrangement of the dormitory rooms. The drapery effect is formed by using waterproofed wallpaper at the windows. The paper dado is at a height of 4 feet from the floor between the color combinations.

EXTERIOR VIEW OF NURSES' HOME

Massillon Hospital Presents "The Nicest Nurses' Home per Cubic Foot"

E. J. LINCKE
Superintendent
Massillon City Hospital
Massillon, Ohio

ALBRECHT and WILHELM
Architects
Massillon, Ohio

THE new nurses' home at Massillon City Hospital, Massillon, Ohio, accommodates 40 students and one house mother. It provides a library, large and small living room, recreation room and classroom facilities for the student body.

One of the most interesting rooms of the home is the "gab room" on the second floor where the students enjoy evening snacks and get-togethers. There is a large recreation room located in the basement for indoor entertainment and a playground at the rear of the hospital for outdoor sports.

Each floor contains a utility room in which the students do their personal laundry.

All activity of the other nurses' homes is centralized in this new structure. The switchboard in the main office of the new home controls all telephones located in the other homes.

This home is furnished and decorated much like the average private residence for the comfort and enjoyment of the students.

FOR OUTLINE OF CONSTRUCTION DETAILS SEE PAGE 58

Student nurses watch an instructor demonstrate the technic of intravenous medication in the practical arts classroom.

OUTLINE OF CONSTRUCTION DETAILS

CONSTRUCTION: Brick and Indiana limestone exterior, fireproof throughout. Floors, reenforced concrete on bar joists. Interior partitions, brick and terra cotta tile. Stairways and railings, steel and wrought iron. Roof laid on 1 inch insulation.

HEATING: Two-pipe vacuum low-pressure steam with moderator control. Convector radiators.

LIGHTING: Direct.

WALLS: Toilet walls, matt-glazed ceramic tile. All other walls, painted plaster.

FLOORING: Vestibule, lobby, toilets and stairs, terrazzo. All other floors, asphalt tile.

Above: View of one of the two utility rooms that are provided for the use of the students. Each room is equipped with two laundry tubs, two ironing boards and an electric clothes dryer. Left: A corner of the library, which is adequate to accommodate all students in the home. Below: A student talks things over in the office of the director of education.

CEILINGS: Library, office, lecture room and corridors, acoustic tile. All other ceilings, painted plaster.

COSTS: General construction, $89,932; plumbing, heating and ventilating, $18,712; electric wiring, $6138; total cost of building, $114,782; equipment, $15,000; volume, 167,100 cubic feet. Cost per cubic foot for general construction, 53.8 cents; cost per cubic foot for plumbing, heating and ventilating, 11.2 cents; cost per cubic foot for wiring, 3.6 cents. Total cost per cubic foot for building, 68.6 cents. Cost per bed for building, $2869.50. Cost per bed for equipment, $375.

— Honorable Mention Essay —

MEDIOCRITY Is the Charge *against psychiatric hospitals*

Two Basic Causes Are ▶*Politics and* ▶*Public Ignorance*

MILTON LOZOFF, M.D.
Milwaukee

MARJORIE MORSE LOZOFF
Milwaukee

LACK of interest in the public psychiatric hospitals and the resultant mediocrity of the staff members is depriving hundreds of thousands of mentally ill patients of the best modern therapy. Some hospitals have many features of a well-rounded psychiatric treatment program, yet few of them are characterized by a vigorous, progressive program offering the best possible psychiatric treatment to the majority of their patients.

None of the present technics is adequately utilized in most hospitals, nor will innovations be initiated rapidly or widely enough unless there is widespread improvement in the personnel of the average public psychiatric hospital. Because we believe that an alert, skilled staff would naturally be interested in research we shall concern ourselves primarily with the problems of obtaining superior personnel and creating public progressive superintendent.

Every Employe Plays a Part

It is perhaps a truism that the essential feature of psychiatric treatment is the relationship of therapist and patient. The treatment of psychiatric patients in hospitals, however, goes on twenty-four hours a day. As a result, every hospital employe who has any contact with patients has by virtue of that contact a potential therapeutic rôle, although it may be a minor one. Therefore, the quality of a hospital's therapeutic program depends upon the abilities of the professional and nonprofessional staffs and the guidance of a stimulating and progressive superintendent.

We are not chiefly concerned with instances of abuse of patients although abuses exist in some hospitals. Of greater import is the problem of lifting the majority of public hospitals out of the morass of mediocrity which is their chief characteristic. Let us then examine the factors that contribute to this mediocrity of service, the factors that interfere with the full utilization of the resources, personnel and therapeutic programs which these hospitals may already have at their disposal.

An obvious difficulty in some states is the undue influence exerted by political considerations and the spoils system. State hospitals are often the dumping ground for all sorts of political hangers-on and patronage seekers who are indebted to a politician for their positions. As a result everyone feels insecure and the atmosphere is scarcely conducive to the concentration of efforts on a therapeutic program for the benefit of the patients.

Civil service or the merit system is used by many states to combat the evils of the spoils system. Unfortunately, while civil service may eliminate corruption, it tends to encourage mediocrity in public hospitals. This is primarily because employes are so well protected by various regulations that once they receive a permanent appointment they cannot be discharged except for incompetence or the grossest derelictions of duty, and then discharge may occur only after extensive hearings before a civil service commission.

Not infrequently employes belong to organizations primarily concerned with the protection of jobs and these organizations may bring pressure upon the commission, forcing it to be extremely cautious about discharge. It is thus difficult to discharge any employe, either professional or nonprofessional, simply because he is mediocre or because of personality factors.

Do Not Evaluate Personalities

The personality of employes in psychiatric hospitals is important because of the potential therapeutic value of their relationship with patients. Yet most civil service examinations are not able to evaluate personality traits. Some employes of state hospitals seek these frequently underpaid, often unpleasant occupations because working with psychotic patients gratifies their neurotic needs.

Although some of these employes have a harmful effect upon patients, it is difficult to detect such neurotic tendencies through civil service examinations. Yet once such a handicapped person has obtained a position, it is difficult for the superintendent to discharge him because of the subtle, destructive effect of his personality. Such individuals are usually difficult to work with and conflicts ensue among employes, staff and superintendent which interfere with the smooth operation of the hospital, to the detriment of the patients.

Even under civil service certain types of political pressures exist. A disgruntled employe may enlist the

support of his legislative representative or union official, who will harass the superintendent. Although public hospital administrators should be held accountable to the public for their decisions, their time and energies should not be consumed in defending themselves against unfounded attacks. Even those superintendents whose institutions are under civil service must take account of the effect political influence may have upon the size of their budgets and must weigh this factor before acting.

Some Give Up the Struggle

All such manipulations, carried out as they are with no consideration for the welfare of patients, are detrimental to the morale of the professional staff and find expression in the quality of its work. A capable superintendent may succeed in minimizing such influence, but many capable men give up the struggle after several years and either resign or content themselves with mediocre hospital administration.

Capable younger psychiatrists who, under favorable circumstances, would gladly remain in institutional psychiatry because of the opportunities for helping large numbers of people leave such hospitals for other types of psychiatric practice where they need not continually meet these frustrations.

The personality and ability of the superintendent are the most vital factors in determining the character of a hospital. Many hospital superintendents appear to be primarily interested in the security of their positions, in maintaining an organization that will not offend anyone of political importance and in presenting annual reports that emphasize as much the low cost of operation and the returns from agricultural and dairy activities as they do the results of their treatment programs.

If such a person, employed under civil service, makes no major error in judgment, the hospital may stagnate for years without hope of any significant improvement. Such superintendents can be, and are frequently, chosen because residence requirements in some states narrow the choice to men of limited capacities, and because boards or commissions having authority to select superintendents often lack the knowledge of psychiatric hospital administration necessary to evaluate the qualifications of individuals competing for such a position.

All too frequently the members of the boards or civil service commissions are chosen for reasons that have no bearing upon their interest in psychiatric treatment facilities. Sometimes they are public-spirited citizens of quite diverse backgrounds, usually, however, not connected with fields allied to medicine or social problems; sometimes they are appointed because of their political service in a recent campaign. Nevertheless, they are given responsibility for supervising all types of public eleemosynary institutions, including the psychiatric hospitals. They meet only periodically for this purpose and their opportunities for becoming acquainted with psychiatric problems are limited.

By the time they do begin to acquire some realistic idea of these problems, there may be a change in political administration or a new election and a resultant change in the composition of the board, and the process of education must begin anew. Meanwhile, such boards or commissions have an appointive or advisory authority in the selection of a superintendent.

Quality and Standards Impaired

Generally speaking, then, there may be some question whether in many states or communities the power of appointment of psychiatric hospital superintendents is in the hands of people who are best qualified to select the most competent superintendent. In turn, the superintendents who are selected under such circumstances may be unable to undertake the vitally important function of adequately presenting the psychiatric needs of the community to the supervisory boards and other authorities responsible for the guidance and supervision of the hospital's activities. As a result, the quality of the personnel and staff employed and the standard of psychiatric treatment are impaired.

From the foregoing, it should be apparent that before most public mental disease hospitals can hope to provide anything that might be considered adequate treatment for their patients, there must be a change in the socio-political conditions under which they function, in their methods of recruiting personnel and in the working conditions within the institutions themselves.

Such changes would give impetus to more adequate utilization of the facilities and technics already available and the development and expansion of new approaches to treatment. The main question is how to accomplish these changes. Efforts should be made to enlist the support of the public in developing a program designed to attract superior personnel. Such a program could include the following suggestions.

1. Political considerations in the appointment of hospital staff and employes must be eliminated or minimized as far as possible. This type of reform can be accomplished only by an alert, informed citizenry.

2. The selection of at least the superintendent of a hospital should be made by individuals who are alert to the possibilities of good psychiatric facilities and to the community's needs. It is probably unrealistic to expect that government agencies will or should delegate this authority to individuals not directly connected with the government. However, there should at least be advisory boards that can give authoritative recommendations to those directly responsible for making the selection.

These advisory boards might well include the presidents of the state or local medical societies, the deans of the state or other medical schools, the president or delegated member of the local or regional psychiatric society, the president of the state mental hygiene society and individuals who are equally well recognized in their professions. In addition, leaders of national psychiatric organizations might be called upon for advice, particularly when a state's own resources for professional counsel are limited.

Members of the appointive agency and advisory boards should have overlapping terms of sufficiently long tenure so that at least part of the group is always well informed about the hospital's activities. It is the hospital superintendent's function to keep these groups alert to the hospital's needs and problems. Such boards can be of great support and guidance to a conscientious hospital superintendent instead of a source of frustration.

3. No residence requirements or preferences should be made for applicants for at least the positions of superintendent or clinical director, hospital administrator and the heads of important professional departments, such as superintendent of nurses, chief social worker, chief psychologist and heads of the occupational and recreational therapy departments. After all, the primary function of the hospital is to provide the best possible treatment for its patients, not to provide jobs for residents of a particular state or community.

4. Public psychiatric hospitals frequently suffer because they attract as senior physicians a type of psychiatrist who is concerned with a secure, modest livelihood and is content to do a plodding, mediocre job. The hospitals find it difficult to retain stimulating junior physicians and residents because their salaries are poor and the environment is lacking in stimulation.

It might be possible to remedy these defects and attract vigorous older men and women to key positions and stimulating younger people to junior positions if the hospitals were reorganized with psychiatric training as one of their chief objectives. Public psychiatric hospitals have an unparalleled advantage as training centers because they serve a preponderance of the institutionalized psychiatric patients. This variety of experience is invaluable to individuals training for the psychiatric field regardless of what their future plans may be.

Capable men and women would be attracted to senior positions in public psychiatric hospitals if these positions enabled them to teach and inspire novices, engage in research and serve large numbers of patients. Positions of administrative officials and chiefs of departments should be well compensated in order to attract good teachers and practitioners and to make them want to retain their positions.

There should be more residencies in public psychiatric hospitals and they should be for overlapping periods. Residencies should be for periods of from three to five years and should be sufficiently well compensated to enable a young doctor to support himself and family but not well enough to make him content to retain his job too long. If it is feasible for a junior staff member to become chief of a department after this period he should remain in the institution, but otherwise he should be encouraged to find another position.

Under this plan there would be a continuity of program under the guidance of a fairly permanent, stimulating senior staff with a regular turnover of enthusiastic, fresh young personnel in the junior positions. It is difficult to imagine such a staff offering mediocre service to the public.

5. The superintendent should be freed as much as possible from routine administrative matters. These should be delegated to individuals trained in hospital administration, but, of course, the final authority and responsibility should rest with the superintendent. However, he should be able to devote the major portion of his time to supervising various aspects of the therapeutic program, the training of the hospital personnel and the relationship of the hospital to the community.

6. Civil service procedures should be made more flexible. The hospital superintendent should be given greater authority in the hiring and discharge of professional and nonprofessional employes. While the selection of employes should certainly occur through civil service, it should be possible for a superintendent to dismiss those who he feels are inadequate to their responsibilities or who are out of harmony with his aims in developing a therapeutic program.

This action should be possible without long drawn out hearings before civil service commissions under regulations that hinder the elimination of the mediocre or inadequate individuals from the civil service rolls. It should be made possible for a superintendent to remove physicians and department heads who, as sometimes happens, may actively, though subtly, sabotage his program.

At the same time, it should of course be possible to remove a superintendent who, after a reasonable length of time, fails to provide a community with the best psychiatric facilities that are possible within that community's resources. A superintendent who lacks the facility for adequate, equitable personnel management has no place in this type of position. The public is entitled to the best services it can possibly obtain and it should not be handicapped for years because of too rigid civil service regulations.

7. Improvements should be made in the selection of nonprofessional employes and innovations should be introduced to make them more valuable aides in a therapeutic program. As their personalities are of equal importance to their occupational skills, psychological tests should be given applicants individually or in groups.

Such tests as the Rorschach, Thematic and Apperception reveal overt and latent neurotic and psychotic traits that should be considered when selecting an employe who will work with mentally ill patients. Skillfully conducted personal interviews should be given prospective employes.

The employe should be carefully observed during the probationary period and this period should be long enough to enable the probationer's superior to determine whether he is personally and occupationally suited to the job. These jobs should be well enough paid to attract and retain competent employes. The professional staff should conduct lectures designed to inform the employes about hospital and community problems and therapeutic procedures.

8. The social service department, under psychiatric supervision, should offer case work services to employes whose emotional problems are impairing their efficiency. As a result of discussing their problems, employes might be more content, conflict among them might be lessened and the patients would benefit from an environment comparatively free from tension.

Of primary importance in the improvement of public psychiatric hospitals is the development of public interest and desire for better psychiatric facilities. The present hour offers many opportunities for the accomplishment of this aim.

Because of the efforts and demonstration projects of various organizations and because of the current concern about the psychiatric casualties of war, the public is much more

aware of and interested in psychiatric problems. For the most part, however, this interest is not being utilized for the improvement of psychiatric hospitals.

This increasing reservoir of potential public desire for better psychiatric facilities should be exploited by a well-organized campaign that reaches into the communities directly concerned and deals specifically with the problems of each community.

The national medical and psychiatric societies long ago established certain minimum standards and criteria for adequate psychiatric care. However, since this knowledge is primarily limited to professional groups, such standards are ineffective because the public at large does not know of them and therefore does not question whether its local facilities meet these criteria. If they were more widely publicized and the shortcomings of the local facilities were emphasized, perhaps some communities would bring pressure upon public officials to improve the psychiatric hospitals.

We believe that a well-organized campaign, tailored to meet local, or regional requirements, can do much to stimulate a demand for constructive action in many communities which at present are perhaps blindly complacent about their psychiatric facilities. There are a number of influential groups in most communities whose interest could be aroused in this direction.

Professional Groups Can Help

For example, women's clubs such as the League of Women Voters, business, professional, labor and church organizations and other groups that have an interest in social and community problems should be made aware of the psychiatric needs of their communities. Attempts should be made to educate newspaper editors and other molders of public opinion along these lines.

Unfortunately, a campaign for public education on this subject requires technics that are not simple. Although speeches before public gatherings and articles in the newspapers can arouse public interest if they are presented in a stimulating way, personal interviews are the most effective. These involve a great deal of time, labor and skill. A demonstration unit ought to be established to undertake this door-to-door type of educational project. Funds for such units might be advanced by some national organization interested in improving public psychiatric hospitals.

The social service department, under the guidance of the superintendent and with the support and assistance of the staff and employes of the other departments, is the logical group to engage in such a project. Social workers are skilled in community organization and are able to describe the conditions and needs of their specific psychiatric hospital to the public.

These interviews could advantageously be combined with some hospital program involving the community, such as the development or expansion of out-patient clinics or a foster home program for patients. Although such projects may be valuable therapeutically, we are here primarily concerned with them as a logical reason for interpreting the hospital and its program to the community.

Social Worker Has Many Contacts

For example, a worker seeking foster homes for psychiatric patients has to interview scores of community leaders to obtain the names of potential foster families. Then, to obtain a few suitable homes, the worker may have to telephone or interview hundreds of individuals. In each of these interviews, it is necessary to describe the work of the hospital and the nature of mental ill health. Whether or not a contact results in a foster home, it will result in a more informed citizen.

Similarly, a worker who is encouraging a minister or physician to refer patients to an out-patient clinic will have to describe the facilities and services of the hospital. All of these interviews will help local citizens to understand more about the work of a mental disease hospital.

An objective study of the conditions within a specific hospital should be made so that the deficiencies and needs of the hospital can be clarified. If such a study reveals a need for improvement, the worker can return to those individuals whose interest has been aroused and attempt to enlist their support in bringing about the recommendations.

If a large number of interested citizens write their legislators about improvements they desire in a specific hospital, constructive improvements or investigations can be made. Relatives of patients and former patients might be eager to add their voices to demands for improvements if they have such needs interpreted to them.

A social worker connected with the hospital seems well qualified to do this because she combines a professional knowledge of psychiatric problems and their effect on the community with an ability to interpret psychiatric conditions to the public.

This allocation of function to the social service department should be considered as only a part of the general public relations job of the entire hospital staff. The superintendent's interpretations to his board and other public officials are of primary significance. Each staff member or employe should be able to answer intelligently questions about the hospital, and an educational program planned by the superintendent and professional staff should be directed toward this end. The professional staff should also be ready and eager to give public speeches and assist with newspaper articles.

Comments and reactions of the public should be carefully heeded as the citizens' suggestions can be valuable in helping local hospital authorities develop a psychiatric program that meets the needs and problems of the particular locality. Once the public's interest is aroused, a long-term program should be developed to keep it constantly aware of the activities of the hospital.

Must Fulfill Responsibility

Efforts should be made also to educate the public concerning the therapeutic facilities available, some of the problems involved in the treatment of psychiatric patients and their subsequent readjustment to the community and the various ways in which the treatment facilities can be improved. Only by doing this can the public psychiatric hospital completely fulfill its responsibilities to the community and to its present and future patients.

By educating the public concerning the hospital's activities, it can develop a public opinion favorable to the improvement of psychiatric facilities and the adoption of new therapeutic technics. Thus the caliber of treatment actually available to the patients can also be materially improved.

Motion pictures on health subjects serve the dual purpose of reducing the anxiety, boredom and restlessness that prevail in the clinic waiting room and educating the patients in matters relating to health and hygiene.

Photograph from Menorah Hospital, Kansas City, Mo.

EDUCATION While They Wait

ELIZABETH M. FERBER
Shoemaker Clinic, Cincinnati

ARE you always calm, cool and collected, even while sitting in a doctor's or a dentist's waiting room? Or do you become annoyed by the restlessness of others? Are your nerves put "on edge" by the inescapable movements of people who sit, wait and fidget; or who pick up one magazine after another, wondering why periodicals in waiting offices always attract, but seldom hold, attention? Are your own feelings of apprehension and irritation deepened by enforced self-preoccupation, caused just by being in such an environment?

Perhaps you are a doctor's assistant, working in an office adjoining the waiting room. You find it difficult to concentrate on the task at hand because Johnny Jackson has just discovered the intriguing possibilities of converting the waiting room into a playground. Your reactions to that are better left unwritten.

Hum of Voices Is Distracting

You may be a physician, one of many in a suite or in a busy clinic, trying to listen to Richard White's chest above the confounded hum of voices, incessant and distracting in its monotony, while your patient subconsciously strains to hear what goes on on the other side of the door.

Or as a director of a medical institution you are caught in the vortex of the subtly surcharged atmosphere of a clinic or hospital. In an organization dedicated to the relief of pain, distress and tension, feelings of helplessness and resentment intermingle with impatience, irritability and ever-present anxieties.

Or quite simply, you may be one of the great number of workers interested in promoting health education. In order to make the best use of all mediums, you know that much thought and time are necessary to plan and carry through a health education program.

If you fit into any of these categories you may want to know how one midwestern clinic solved the "waiting room problem" while putting into effect a program designed to help and reassure patients.

It really started not as an experiment, but as an expedient. During Health Week, 1943, the Shoemaker Clinic, Cincinnati, as usual was asked to participate in a well-integrated city program. The ambitious contributions of past years were out of the question, precluded by insufficient staff and lack of time.

It was decided to show motion pictures on health and related subjects, with the foreknowledge of some of the difficulties this would entail. The physical characteristics of the waiting room presented obstacles: patients might trip over rubber runners on the floor when the room was darkened or, if sound pictures were used, the voices might interfere with examinations. However, Dr. Jerome Zeigler, medical director, thought that one day of inconvenience was a small price to pay for active participation in an established custom, observation of Health Week.

The help of the health education secretary of the Anti-Tuberculosis League of Cincinnati was enlisted. Six pictures were selected, which

covered different phases of health activities. They were: "Prenatal Care"; "Food and Magic"; "Let My People Live"; "About Faces" (on dental care); "Water, Friend and Enemy," and the first part of "Judy's Diary," the story of a day in the life of a six months old girl. These pictures had a running time of about ninety minutes and were varied enough to capture and hold the attention of all age groups and both sexes.

The clinic house organ, *Solomon Sez,* carried short features pointing up the topics, which were illustrated by stick drawings. These were the work of the health education secretary, also.

The response of the patients was not only unexpected but gratifying. They had been requested to criticize, make suggestions and in other ways indicate their reactions to this new departure in the clinic waiting room. A surprising number asked whether the program could be made a regular one for "regular patients."

Now It's a Weekly Feature

They were generous with suggestions as to the type of pictures they wanted shown and their reasons. So a program which started for one day during Health Week was expanded to a bimonthly, then monthly and now weekly procedure. Pictures stressing certain health subjects are shown again and again, sandwiched among those on canning, on "Why Moths Leave Home," "Behind the Smile" and similar topics.

Because the motion pictures were decided upon as a potent health education medium, it is especially satisfying when patients tell of their experiences.

One man had seen several showings of motion pictures before he admitted to himself that they might apply to him. Usually, he had accompanied his wife to the clinic. She wondered a little when he repeatedly came with her but was enlightened when he finally asked to be examined, to "find out whether I am sick." He was a very busy man and "had no time to be sick, but I want to be sure I can carry out some of the plans I've made."

He reached this conclusion after seeing "They Do Come Back" for the sixth time. A persistent cough and loss of weight had been worrying him, but "I didn't want to talk myself into something." The picture made him realize the importance of early examination and diagnosis and proper care.

"Kind of tough to have to give up and go to the hospital, but if that is what I need, I guess I might as well accept it. I have read a lot about tuberculosis and heard some lectures. I always thought I was too strong and healthy to get it myself, and I didn't believe that anything could be done for the man who had it. Guess I was just afraid, and certainly I spent months worrying about it. Had to keep on working, you see. But that picture and some of the others made me realize I had not been too bright or I wouldn't have put it off so long, this examination."

The patient also insisted that his young daughter, an adolescent of 13, follow the recommendations of doctors when she was found to be malnourished and in need of additional rest periods. Unexpectedly he found that relatives who were asked to cooperate to make hospitalization possible were really his friends.

Motion pictures as a medium for health education serve a twofold purpose. Not only do patients learn, but physicians, social workers and other clinic personnel have found that reassurance given to people by seeing factual evidence frequently helps to clear up fear in the presence of illness, as well as to correct misconceptions and unwarranted anxieties.

Fear of Cancer Removed

A 34 year old woman who had a lifelong dread of cancer saw "Choose to Live" several times. Then she asked for a thorough physical examination and learned to her intense relief that the condition that caused her so much physical and mental discomfort required surgery but was not malignant. Incidentally, it was unnecessary to ask for psychiatric consultation once the diagnosis was made and explained to her.

The picture "When Work Is Done" discussed juvenile delinquency and enabled one troubled mother to help solve the problems created by the unsocial tendencies of her young son.

Attitudes of patients toward physicians and clinic workers are changing. Friendliness has replaced the sullenness frequently evoked by fear. An understanding of what the doctor tells him induces a much more cooperative attitude in the patient. Methods and technics of obtaining histories and making examinations are identified with personal experience and have increased the patients' desire to know more about the factors in their lives that make medical care necessary.

Associated with this increased desire for knowledge is the rapid disappearance of restlessness, annoyance and tension which frequently prevailed not only among the patients in the waiting room, but among physicians, social workers, nurses and office workers trying to get on with their respective jobs in the clinic.

The by-products of motion pictures in health education are as impressive as attaining the main objective and the workers in the clinic responsible for initiating the "Education While You Wait" program feel amply repaid.

Who Goes There?

THEY say that a prophet is without honor in his own country. I remember the day when the great Doctor Goldwater stepped into his assistant's office and complained to me about the admitting room clerk. He had just come from the admitting office, after having been asked his name and what he was suffering from!

We busy executives manage to achieve invisibility and anonymity at times, as, for example, when I step down the corridor and a stranger addresses me with the question: "Where is Doctor Bluestone's office, please?" and I point, while answering, "There!"

Another favorite way the stern disciplinarian can show sympathy and understanding, under the cloak of anonymity, occurs when, during a tour of inspection, he catches somebody breaking the rules. "Don't let the director of the hospital see you doing that!" he gently remarks, and is content with the admonition.—E. M. Bluestone, M.D., *director, Montefiore Hospital, New York City.*

Extract from Doctor Bluestone's letters to the Hospital Administrators' Correspondence Club.

Multiphasic Personality Inventory

A study of psychological problems of patients as an aid to clinic efficiency

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IT IS often stated that from 30 to 60 per cent of the patients who come to a general out-patient clinic will be involved neurotically to a definite extent so that they are at least psychosomatic and, frequently, clearly psychiatric problems. We are recognizing as never before the importance of these psychosomatic conditions, and the economic waste of handling psychological problems by purely organic approaches is increasingly recognized. However, the internist or general practitioner can hardly take the time or devote the effort properly to prepare himself and practice psychiatric diagnosis routinely, even if he is so inclined. Some method must be worked out by which the patients can be evaluated, at least roughly, with a minimum of professional time and effort.

Identify Neurotic Patients

The Minnesota Multiphasic Personality Inventory seeks to arrive at such an evaluation. Three scales of the Multiphasic Personality Inventory[1, 2] are of particular importance in the identification of neurotic patients. These scales are designated as Hs, D and Hy. They were established by studying the responses of psychoneurotic patients with hypochondriasis, some form of depression and hysteria, in the neuropsychiatric division of the University of Minnesota Hospitals. The responses of which the scales are composed were identified by comparison of the frequencies of actual answers to test questions of the three carefully selected criterion groups with a large sample of presumably normal people.

In the selection of final items for the inventory no attempt was made to establish a theoretical basis for the item beyond the fact that it showed a different percentage of occurrence among neurotic persons of the given type as contrasted to the normals. This procedure has been more completely described elsewhere.[3, 4, 5]

Not all neurotic patients receiving one of the three diagnoses will have high scores on the inventory. This is presumably due to several factors. First, for either conscious or unconscious reasons some patients appear to hide their problems successfully in answering the inventory. Second, there are patients whose symptomatic pictures are atypical enough so that they cannot be identified by this method, which assumes a degree of similarity of one patient with a given diagnosis to the other on the items available. Finally, the diagnosis can be wrong.

In routine use, the patient's ratings on the three scales (locally referred to as the "neurotic triad") are given in terms of a standard score in which 50 represents the normal average and 70 represents an amount of deviation from the average found in about 5 per cent of the population. In our experience with the scales, more than half the patients given a clinical diagnosis of hypochondriasis, depression or hysteria will receive a score of 70 or more on the appropriate scale. Conversely, and in certain respects more significantly, nearly all persons who receive high values on a scale or scales will be seen clinically to be characterized by some of the symptomatic patterns of the indicated diagnoses.

The original idea behind the initiation of multiphasic research was dependent in part on the hope that the ultimate outcome would be a device suitable for preliminary evaluation of all patients. Although the results as they have appeared have been far from perfect, there has been ample justification of the original hope of a useful device. While some cases with neurotic involvement will be missed by these measurements, the cases identified by them are significantly deviate and worthy of special attention. If the clinician does not feel qualified to extend his investigation beyond the verification of the presence of a neurotic problem, he may refer it to a specialist as he feels the need or he may at least continue his therapeutic efforts in the somatic field, recognizing that he is working with a more extensive and complicated problem than might have appeared without the inventory.

No Special Selection Made

The present data are derived from the records of 219 routine patients admitted to the general medical outpatient clinic of the University Hospitals who were given the multiphasic inventory as they waited their turn at the clinic. No special selection was made of these patients beyond their willingness and ability to take the inventory. They were approached by the nurse in charge and were merely told that this was a part of the admission procedure. Of this group 156 were females and 63 males. The majority were first

[1] Hathaway, S. R., and McKinley, J. C., A Multiphasic Personality Schedule (Minnesota): I. Construction of the Schedule. Journal of Psychology **10**:249-254, 1940.

[2] McKinley, J. Charnley, and Hathaway, S. R., The Identification and Measurement of the Psychoneuroses in Medical Practice. J.A.M.A. **122**:161-167, 1943.

[3] McKinley, J. C., and Hathaway, S. R., A Multiphasic Personality Schedule (Minnesota): II. A Differential Study of Hypochondriasis. Journal of Psychology **10**:255-268, 1940.

[4] Hathaway, S. R., and McKinley, J. C., A Multiphasic Personality Schedule (Minnesota): III. The Measurement of Symptomatic Depression. Journal of Psychology **14**:73-84, 1942.

[5] McKinley, J. C., and Hathaway, S. R., The Minnesota Multiphasic Personality Inventory: V. Hysteria, Hypomania and Psychopathic Deviate. Journal of Applied Psychology **28**:153 1944.

admissions, although there were a number of readmissions among them. These patients, after testing, continued in the medical clinic and in appropriate cases were referred to other clinics.

As a first procedure after the test was scored, the charts of the 63 men were reviewed individually by a major member of the staff of the departments of neuropsychiatry and medicine.* This review followed the original admission of the patient by not less than three months and was made entirely independently of the multiphasic profile obtained from the inventory. These two staff men agreed upon a rough assortment of the problems into three groups as seen in the charts: patients with clearly organic problems, patients with psychosomatic or undiagnosed problems, and those with clearly neurotic problems. This assortment was, of course, somewhat rough since the patient himself had not as a rule been seen by either of the staff men.

It is understood that a patient with a clearly organic problem may concurrently or independently have also had a neurotic problem which was not presented as a complaint. Similarly, patients with neurotic problems as complaints may have had concurrent organic difficulties that would sometimes be emphasized in the medical clinic so as partly to overshadow the psychological aspect of the problem.

D Scale Showed Rise

Eighteen men were found by this method to have presented rather clear organic problems. The diagnoses for these men were cataract, fracture, hernia, carcinoma and others similar to these. No one of these men was found to have a clearly abnormal score on Hs (hypochondriasis) or Hy (hysteria) when the multiphasic profiles, or results, were studied. A number of the men showed significant rises in the D (depression) scale, but this scale is neglected here since one of the incidental findings was that men more than women were characterized by rise of the D scale at the time of admission to the medical clinic.

Among the 63 men there were 19 clearly neurotic cases. Of these, only four had scores on Hs and Hy that were below 70. A number had greatly elevated points among other scales. The 26 remaining cases not classified as clearly neurotic or clearly organic included many of the diagnoses that are commonly considered psychosomatic as well as other more complicated conditions, chiefly relating to the viscera. Of these cases, 11 had Hs and Hy scores that were both below 70.

These data are strongly indicative that an important percentage of the neurotic and psychosomatic cases could have been recognized through the use of the inventory at the point of admission. At most, this would not have entailed the identification of more than one case in about six or eight in whom the psychological factors would have been relatively unimportant. No evidence beyond speculative thinking is available as to the value of such an early recognition of the psychological problem. It was the feeling, however, of both staff men who reviewed these cases that a fair proportion of the clinical work-up as it was executed would have been unnecessary if the implications of the inventory had been properly considered early in the work-up.

All the data were collected in the summer of 1941 and nothing was done with the records of women patients until the fall of 1945. At that time the charts of the 156 women were pulled and diagnoses were obtained. Since careful evaluation of the charts by a committee proved to be too arduous and not productive enough of specific data, the charts of these women for whom multiphasic profiles were available were not critically reviewed.

For a simplified treatment of the data, the personality profiles of these women were divided into three groups. The first group was made up of all "neurotic triad" types of profiles having two or more of the neurotic triad scales elevated to 70 or above. These women were neurotic as indicated by the inventory.

The second group of profiles was chosen from those having no score that indicated neurosis elevated as high as 60. These women were therefore free of severe neurosis as far as could be predicted from the inventory. The third group, profiles having some other abnormality or lying in the borderline zone between the two groups described, was discarded.

The first two groups will hereafter, within the described meaning only, be referred to as the abnormal and normal groups. Of the 156 women, 28 had profiles that were abnormal and, by chance, 28 also had profiles that were normal.

Diagnoses Are Varied

Only the most generalized findings are available. Naturally, the diagnoses are highly varied in both groups, although the difference between the groups is quite marked in terms of the length of the "patient's complaints" paragraphs written in the chart. Generally the complaints of the abnormal group are especially diverse and multiple. Typical in this group were backache, pain of indefinite origin, weakness, menstrual irregularity, diarrhea, nervousness and the like. The diagnoses given tend to be cystitis, torsions of the uterus, cystic ovary and glandular disturbances.

Among the normal group the diagnoses were much more specific. They presented such uncomplicated problems as warts, thyroglossal duct cyst, tumor of the finger, varicose veins and the like. Among these cases, however, there are also a number of diagnoses that would frequently be thought of as psychosomatic—for example, asthma, menorrhagia and skin conditions.

The findings on these normal and abnormal cases among the women are not as carefully derived as was the case for the men but are indubitably similar in their import. There is a predictive relationship from high multiphasic values toward complicated diagnoses and elaborate clinic procedures. A rather significant evidence in this regard is afforded by actually weighing the patients' charts. For this investigation, all 219 cases were divided into normal and abnormal, as described for the women.

In the four years that elapsed before weighing, a fair percentage of the cases had become inactive, while others had had an opportunity to accumulate notes and reports in their hospital charts. Naturally, many factors contribute to a heavy chart. The presence of a condition requiring special report forms, such as are used for electrocardiography, will greatly increase the weight of the

*I wish to express my especial appreciation for performing this onerous task to Dr. J. C. McKinley of the Department of Neuropsychiatry and to Dr. Macnider Wetherby of the Department of Medicine.—S. R. H.

chart and if the patient has been admitted to the hospital several times as an in-patient the chart will, of course, gain weight.

Because of this latter fact, those women who were admitted with several pregnancies were eliminated from the chart weight data. There were a total of 46 men and women who remained in the abnormal group and a total of 31 men and women in the normal group. Of the normal group only four, three women and one man, had charts that weighed more than six ounces.

One of these four patients, who had a 24 ounce chart, the heaviest chart observed in this series, finally received a diagnosis of psychoneurosis in spite of her initially normal multiphasic profile. It is possible that the neurosis developed after the first admission to the out-patient clinic, since she was referred at that time for removal of gall stones and was again referred several months later when the diagnosis was extended to psychoneurosis. Of the 46 men and women in the abnormal class, 18, or 39 per cent, had charts that weighed more than six ounces. The occurrence of heavy charts in this group is three times the frequency of its occurrence among those with normal profiles.

These crude data are all the more significant in consideration of the complexities of background for obtaining a given weight of chart. Probably these data more than any other indicate the possibilities for future increases in clinic efficiency that are offered in using an objective device for early identification of psychological problems in patients.

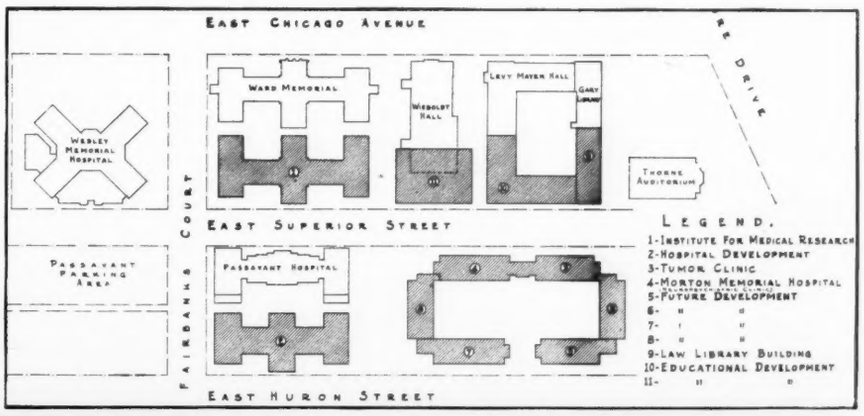
Northwestern University Plans to Expand

A BUILDING and expansion program for its Chicago campus including the development of a great medical center, with major emphasis on medical research, was announced by Northwestern University last month. Ten new buildings are proposed in the expansion plan, which will cost an estimated $90,000,000.

The major unit for the new medical center will be an Institute for Medical Research, planned for intensive, organized investigation into all the unsolved problems of medicine, with emphasis on the diseases of middle and later life, such as heart and circulatory diseases, cancer, kidney disorders, high blood pressure and others. The institute will be housed in a 20 story, $6,000,000 building to be built on vacant property immediately south of the present medical school building, flanked by the Wesley Memorial and Passavant hospitals.

The program also includes development of a $12,000,000 endowment fund to bring top medical research workers to the institute and provide fellowships for encouraging younger investigators.

"The proposed institute faces a remarkable opportunity to contribute to the solution of the tremendous unsolved problems of medical science," Dr. J. Roscoe Miller, dean of the medical school, declared.



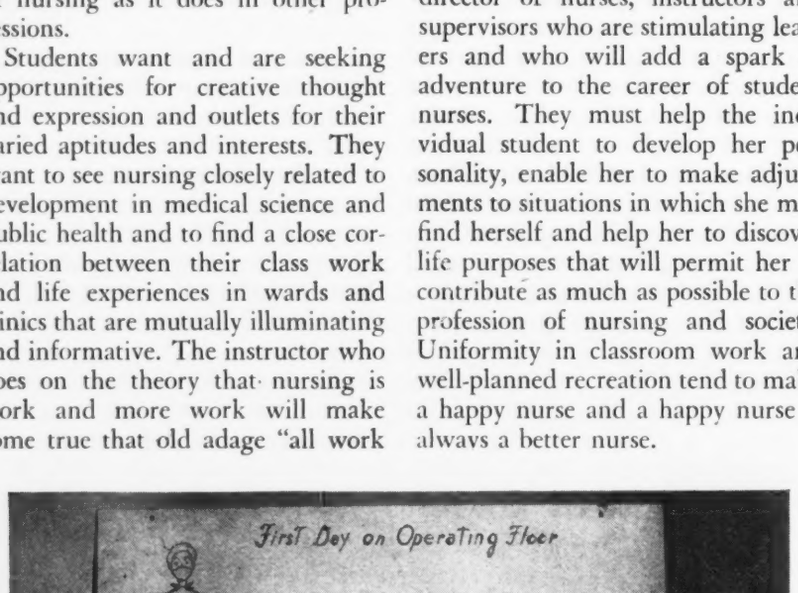
Some Play With Her Work Makes Jill a Better Nurse

JAMES E. MOORE
Former Superintendent
Norwegian-American Hospital
Chicago

A WELL-BALANCED personality depends upon social life and various cultural contacts as well as upon work. Young people need good times, change of thought and contact with others outside their own group. This holds as true in a school of nursing as it does in other professions.

Students want and are seeking opportunities for creative thought and expression and outlets for their varied aptitudes and interests. They want to see nursing closely related to development in medical science and public health and to find a close correlation between their class work and life experiences in wards and clinics that are mutually illuminating and informative. The instructor who goes on the theory that nursing is work and more work will make come true that old adage "all work and no play makes Jill a dull girl" and may create a dull nurse.

Therefore, the first step necessary in a school of nursing is to select a director of nurses, instructors and supervisors who are stimulating leaders and who will add a spark of adventure to the career of student nurses. They must help the individual student to develop her personality, enable her to make adjustments to situations in which she may find herself and help her to discover life purposes that will permit her to contribute as much as possible to the profession of nursing and society. Uniformity in classroom work and well-planned recreation tend to make a happy nurse and a happy nurse is always a better nurse.



For many years student nurses have had little time for outside activities. However, at Norwegian-American Hospital in Chicago the department of education of the school of nursing has tried to remedy this by combining work with play whenever possible. Classroom work is presented in such an interesting manner that the student becomes interested enough to do further research and to delve more deeply into the subject.

Early in their nursing experience students begin to realize that the problem of illness is not simple. In the first few months of their preclinical work, without actually seeing the patient, they learn to see the patient as a whole, to visualize his background, to understand his needs; all these are basic elements of the art of nursing. Many of these classroom problems, as well as personal problems, can be ironed out at an occasional evening jam session in the lounge, followed by coffee and cake.

When drawings and other group work are assigned for classroom projects, the instructors of N.A.H. often invite the students to spend the evening in the lounge, working together on their various assignments. The students gain knowledge and experience by doing research work with others and the work progresses much faster. Students are all together and it isn't necessary to run down the hall to see how Jane is coming along with her work. These gatherings do away with many trying rules about "remaining in their own rooms" and obviate homesickness among students.

Not long ago, close to the end of the term at N.A.H.—time for finals—it was noted that students were spending every available minute studying alone or discussing their work in small groups. Everyone seemed to be working at a tension. The instructors decided something must be done to relieve this tension. Why not display the work of the various classes so that all of the stu-

dents could view one another's activities.

The students were instructed to get all their work of the semester ready for display. Little did they realize while they were stringing wires and hanging posters that they were reviewing all their work and the finals no longer loomed as the "end."

It is gratifying to a student to see her work displayed and it stimulates her to put forth greater effort. The students took such delight in the proposed display that the instructors thought it a good idea to invite the medical staff and supervisors of the hospital to view the work. Some of the finals were past by this time, but the work on the project continued. The lounge turned into a busy workshop and plans grew in leaps and bounds.

The board of trustees of N.A.H., students from neighboring schools of nursing and parents of our own students were added to the invitation list. In addition to creating an interesting exhibit the students were gaining the ability to meet people and converse with them.

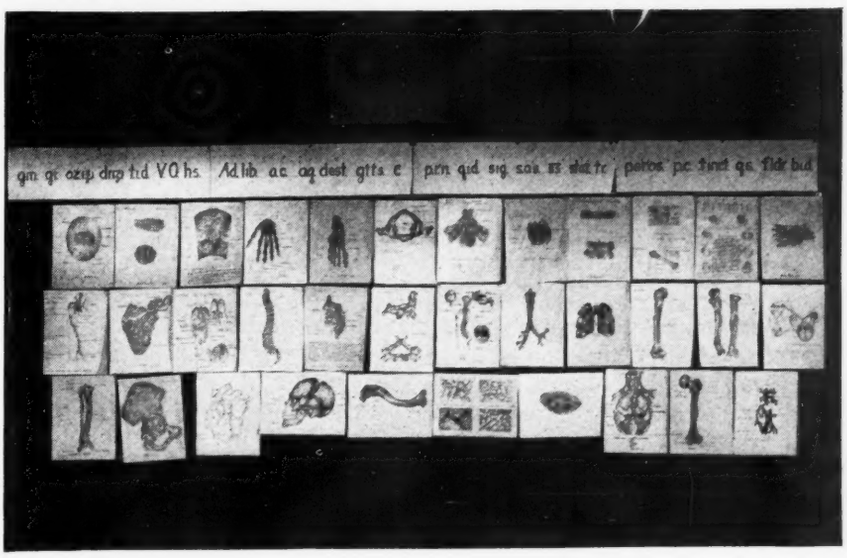
The nursing arts division was represented by procedure demonstrations and posters to explain the important steps in the technic. The nursing history project included an exhibit of dolls dressed in period costumes representative of all the outstanding characters in or associated with the development of nursing. The dressing of the dolls required much research for each costume was complete to the smallest detail. There were 27 student nurses working on this project and each student had one doll to dress.

A miniature operating room portrayed the duties of the scrub nurse and the circulating nurse. The room was complete to tables and miniature, sterile wrapped equipment.

Several small housing project scenes showed the "before and after" effects of the visit of a public health nurse to a home in which there was a communicable disease. In the "before" scene the apartment was dirty and upset, the ill child was playing on the floor with the well children, Father was sitting at the table over a pile of dirty dishes and Mother sat by lamenting over the state of affairs. The "after" scene showed a neat apartment, ill child in bed and away from the other children, Father

JAM SESSION: Student nurses at work and play.

AND WHAT CAME OF IT



These photographs and the one on the opposite page illustrate the results of the work-play project instituted at Norwegian-American Hospital. Above: The dolls portray the history of nursing from earliest days. Below: A series of anatomical drawings. Opposite Page: The amusing drawing accurately describes a student's feelings on her first day on surgery. Below the drawing is a complete miniature operating room.

looking unnecessary in his clean clothes and Mother washing dishes.

The story of drugs as to source, preparation, administration, effects of use, toxic symptoms and dosage was adequately told in a beautiful display of posters and actual samples of various drugs. In the science division all students are required to make a complete set of anatomical drawings which they use throughout their entire training period.

The project, as a whole, represented the cooperative efforts of the student body of our school of nursing and of the instructors. It was graciously received by our guests and a success, educationally and socially.

The Library Comes to the Patient

KATHERINE E. MUFF

Station Hospital
Camp Chaffee, Ark.

A WELL-CHOSEN collection of books may be housed in an attractive reading room in the hospital and attended by a pleasant worker and yet, to the patients who need library service most, the hospital has no library. The library must be brought to the nonambulatory patient.

The mechanical agent is a book cart, a small set of shelves on wheels. Behind it should be a person who knows books and likes people. This personal service is a most important responsibility and a great privilege.

I have scant respect for the librarian who sits in the library typing book reviews while assistants visit the patients. A woman whose feet and back are inadequate to the task of pushing a book cart up and down corridors and in and out of wards for two or three hours is poorly placed as a hospital librarian.

Take Time for Each Patient

It takes time to give good bedside service: five or ten minutes with each borrower, plus the pauses to greet nonborrowers and suggest willingness to serve, plus the time required in going from bed to bed. A calm, unhurried manner is essential. It is better to visit patients less frequently than to be abrupt and in a hurry.

Unless the budget is extremely limited, the book carts put out by library supply houses are good investments, but an adequate homemade one will serve the purpose. The December 1942 issue of *Popular Science* (page HW 436) contained a design for a cart that any carpenter could execute and fit with shelves.

When patients are not interviewed in a manner that encourages requests for books that are not on the cart it cannot be assumed that the book he takes is really his choice. When revisiting earlier borrowers the librarian has some guide to selection of books for the cart; for new patrons effort should be made to show them a specimen of the library's varied resources.

The habitual reader will welcome the book cart with glad cries. Serving him is no problem. The man, or woman, who normally reads very little but, when hospitalized, decides to try it requires time and the librarian's best efforts. The name of some book or magazine he read and liked, even if years ago, will provide a faint indication of his taste. No matter how intelligent he is, his reading ability should not be overestimated.

Except to refrain considerately from presenting books which are heavy to hold or are printed in type that is difficult for a bedridden patient to read, the librarian should try to forget that her patrons are sick or injured and concentrate on serving that portion of the person, or personality, that is not disabled. This attitude has a more beneficial effect upon most patients' morale than one of "sympathy." Even very sick people like to have someone see them as persons, not as medical, surgical or psychiatric problems. Conversation should not stray far from books and reading and all requests for other services should be referred to the nursing staff or to the social workers.

The librarian should pleasantly offer books to every patient but should not expect everyone to accept. Rather than have patients return to their homes to complain that "they were always trying to make me read a book" have it said "they do everything they can to make you comfortable. They even bring books around for people who like to read."

At the beginning of her service the librarian should have a talk with the chief of psychiatry about books for mental disease cases. Thereafter, within the limitations he specifies and using a little common sense, they can be treated exactly as are other patients. The librarian can do positive harm by making them conscious that she considers them incapable of choosing their own books.

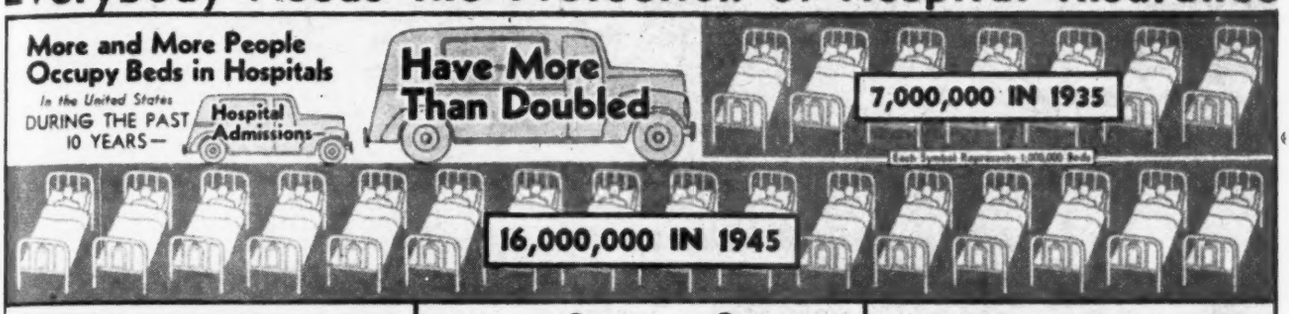
As a matter of routine, it is best to disregard any division of books into "men's" and "women's" tastes. There is a perceptible difference, of course, but it is less than the differences between individuals generally and is not constant.

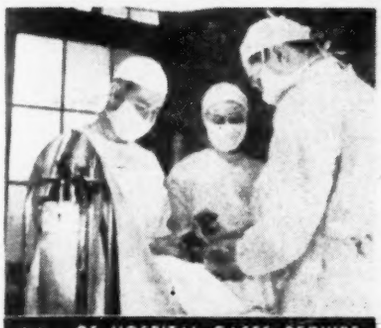
Children Like Old Favorites

Small children, fortunately for the librarian with a small collection, like the old favorites over and over again and like more than anything else to have stories read to them. A mother who yearns to do something will appreciate a book to read to her child and to others who share his room or ward. Nurses on private duty with young children should be offered help in selecting books to be read to young charges.

Older children and adolescents must be interviewed and "fitted" with books. Care should be taken to find a book that the young person will read with pleasure without incurring the disapproval of his parents. Many of them do not know what their children habitually read but while a child is hospitalized is no time to complicate parent-child relationships.

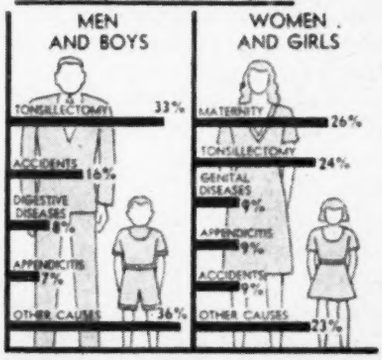
Everybody Needs the Protection of Hospital Insurance

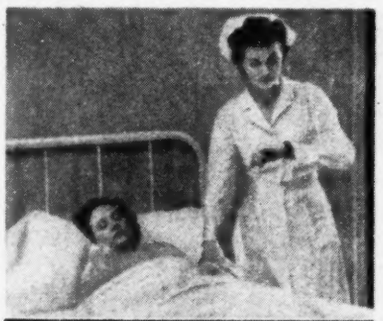




62% OF HOSPITAL CASES REQUIRE SOME KIND OF SURGERY

Why People Go to Hospitals—





30% OF HOSPITAL PATIENTS REMAIN MORE THAN TEN DAYS

THE COST OF HOSPITALIZATION

The expense of becoming a patient in a hospital varies with hospitals and localities. Daily charges for rooms average about $9 for a private room, $7 for a double room, and $5 for a ward. An example of a typical hospital bill is shown here

HOSPITAL BILL
(Not Including Doctor's Fee)

ROOM.	$63.00
9 Days at $7 a Day (Average Stay at Hospital)	
OPERATING ROOM . . .	15.00
X-RAY	15.00
ANAESTHESIA	10.00
LABORATORY ANALYSIS	7.50
AMBULANCE.	12.00
	$122.50

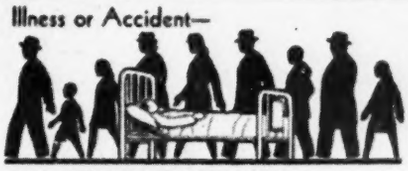
HOW INSURANCE MEETS THIS COST

The average hospital insurance policy pays sickness, accident, surgical and maternity benefits. These do not meet the total hospital and doctor expense, but they do go far toward relieving the patient of financial worry while in hospital

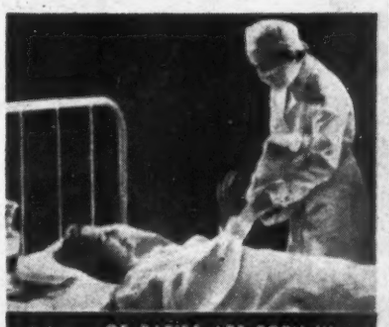
INSURANCE COVERAGE
(Average Benefits)

ROOM.	$45.00
9 Days at $5 a Day (Average Policy Covers Up to 21 Days)	
X-RAY	10.00
OPERATING ROOM . . .	10.00
ANAESTHESIA	5.00
LABORATORY ANALYSIS	5.00
AMBULANCE.	5.00
	$80.00

Illness or Accident—



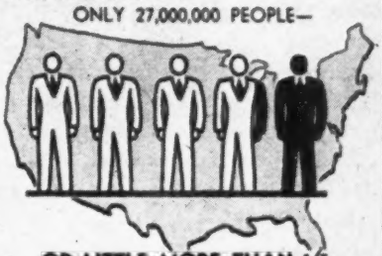
PUTS ONE PERSON OUT OF EVERY 9 IN A HOSPITAL EACH YEAR



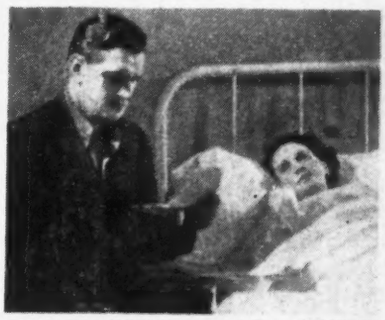
66% OF BABIES ARE BORN IN HOSPITAL MATERNITY WARDS

Great Need for Protection—

In the United States—
ONLY 27,000,000 PEOPLE—



OR LITTLE MORE THAN 1/5 OF TOTAL POPULATION—
HAVE HOSPITAL INSURANCE



$100 OR MORE IS AMOUNT OF MOST HOSPITAL BILLS

This interesting pictorial feature on costs of hospitalization and the need for hospital insurance was published in the Chicago Sun, which recently inaugurated a hospital insurance plan for the benefit of its home subscribers.

Memo to Non-Writing Readers

Helpful hints for the person who "can't write": Just grab a pencil and get at it!

ROBERT M. CUNNINGHAM JR.

TOO many books are written by the wrong people. The presses are stuffed with carefully manicured prose that doesn't say much of anything; at the same time, thousands of thoughtful, energetic people refrain from setting down the words with which, conversationally, they stimulate their friends and associates, on the grounds that they "can't write." It shouldn't happen to an editor.

All the people who say they can't write are wrong. They can too write, in the sense that back in first or second grade they learned to make these little shapes in the combinations and sequences necessary to convey thought. That's the only kind of writing there is; from Wordsworth to Winchell, the differences among writers are not differences in writing but mainly differences in thinking.

We Know We Can Think

Obviously, only a few of the people who think they can't write also think they can't think. (As a matter of fact, most of us rather fancy ourselves as thinkers—a little deception that probably does no great harm.) What they really mean when they say they can't write is that they can't write pretty. This confusion between writing and writing pretty is chiefly responsible for the unhappy fact that many compelling truths and thoughts never get written down. It is also responsible for two of the greatest evils of the printed page: pretty writing that hides shabby thinking, and good thinking that gets fouled up in attempts at pretty writing.

Nearly everybody at one time or another knows something that is worth telling. Most men and women who have useful jobs learn interesting facts, get bright ideas and reason to sound conclusions. The people who get the most facts and ideas, or the best ones, can usually tell them vigorously and often colorfully in any group or on any occasion when they are not handicapped by shyness. Even the pathologically timid person can tell a whale of a story to himself.

But ask your capable man to write a book or an article setting forth the very same facts and ideas that he talks so persuasively and the chances are that if he attempts the project at all, which is unlikely, he immediately starts using words he wouldn't dream of saying out loud and phrases hauled painfully up from the dark closets of the mind and used instead of ordinary expressions because they sound vaguely literary. He is writing pretty, and it is uphill work.

Somewhere along in here, the idea that there is some magic formula to writing sends the nonwriting thinker to the classroom or library for advice; like as not, this is handed down in nicely tailored periods by a nonthinking writer. Often the advice is perfectly sound.

Invariably, for example, the student is urged to shun affectation and woo simplicity. In the confusion of instructions about footnotes, paragraphing, interlineations and which side of the paper to write on, however, simplicity itself becomes another hurdle in the literary obstacle course, and the pupil never does find out that all he has to do is be natural.

Some of the worst monstrosities the language art has ever spawned result from needless straining at simplicity. Frequently, for instance, doctors, engineers and other professional people, in their anxiety to dive to the level of the nonprofessional reader, achieve a primer style of prose with a preachy tone that would offend any reasonably intelligent third grader.

At the other extreme is the author who has to get every long word he knows into every sentence. He never uses a simple phrase if he can think of a complicated one, and he usually can. Now everybody likes to show off a little when the opportunity comes along and there is no opportunity like writing. What these writers with the long-word complex forget is that for the discerning reader, the only one whose opinion matters, they can show off most effectively by presenting their facts or ideas as painlessly as possible, uncluttered by a lot of language. Only dopes are impressed by syllables as such.

Let Editor Worry Over Syntax

But, members of the "I can't write" school are likely to complain anxiously, what about grammar? Well, what? For the person who has something important to say, the best thing to do about grammar is just what he does when he talks—forget it. It will only get in the way. Fear of being ungrammatical is a constant inhibiting worry to most nonwriters, even though there is no particular reason for them to have more than a nodding acquaintance with syntax.

On the other hand, professional writers, who should know the rules, as a matter of occupational pride if for no other reason, just plunge happily onward, dragging their participles behind them. Examples of

this may be found in every period from Moses on.

Carl Sandburg, for one, whose place in contemporary letters is unassailable, sometimes writes so loosely that the reader wanders around in his sentences for hours looking for a period. Yet there are few who would say that Sandburg is any less rewarding on this account.

Another superb American writer of our time, John Dos Passos, learned all the rules at Harvard and then threw the book away when he started to write. You have to hunt pretty hard to find a sentence of any kind in the great Dos Passos trilogy, "U.S.A.," but this is blue chip writing by anybody's standards.

F. Scott Fitzgerald, in contrast, undoubtedly laid down the smoothest, fanciest, most polished prose of any American of the 1920's, when the country was bursting with Class A writers; yet, while he has a devoted little group of fanatical followers, Fitzgerald is not read much any more. He did go on and on about Princeton and the Ritz and Harry's New York Bar, and those subjects simply don't have staying power.

Blank Paper Scares Them

Among other stumbling blocks to natural writing for most people, the mechanics of the job present a nasty problem. Dictating, a good method for those whose whole effort should be aimed at writing the way they talk anyway, is out of the question for all but a few. A blank sheet of white manuscript paper, the usual starting point, is one of the most effective thought-stoppers that has ever been devised; swiftly it will divert brilliant thinking into the most idiotic, irrelevant channels. So will the typewriter and, in severe cases of paper fright, even the fountain pen.

Often the author's best bet is to sneak up on his thoughts while they aren't looking, so to speak, and start scribbling them down on the back of an envelope or a piece of butcher paper. Everybody who writes anything knows that the beginning is the hardest part; once you're well started you can usually switch over from the butcher paper without dropping a comma.

A fairly good wrinkle for those who still have trouble is to pretend they aren't writing for publication at all. "Dear Joe," you may write on the back of an old banquet menu, as though you were tossing off a note to a good friend or colleague. "I think you'd be interested to know about a new gimmick we have worked out down in the diet kitchen. . . ." Then keep on going, just as if you were telling Joe across the lunch table or in the office or over the phone.

This way, you will write the story the way you would tell it—the way it ought to be told or written. You will begin without the agony of a literary introduction, and you will stop at the end of your fact or story or idea, not two pages later. You'll forget your self-consciousness about grammar, because Joe doesn't know an adverb from an Arab, any more than you do. When you've finished and are reading it over to cross out the words you've written twice and put in the words you left out, you'll be quite astonished at how good it sounds.

You will find that writing is not at all the painful, time-consuming task you thought it was. Instead, you will find it exciting and deeply satisfying. You will gladden the heart of some editor or publisher who will happily overlook and, if necessary, correct any grammatical transgressions, if your ideas are stimulating. He will even accept the original butcher paper copy, if they are stimulating enough.

Of course you can't write. But you can think, can't you?

WHO WILL HELP
the chronically ill?

This letter tells its own story of the desperate need for facilities for the care of the long-term patient, particularly for the patient who doesn't need or want "charity"

Miss Edna Nicholson
Director
Central Service for Chronically Ill
Chicago

Dear Miss Nicholson:

When I approached the door on which was the sign "Central Service for the Chronically Ill," I stopped and prayerfully it occurred to me that perhaps, just perhaps, within these doors was the solution to my problem. I had gone to so many places, interviewed so many people and, though there was always much understanding and sincere sympathy, the answers to my questions were never forthcoming and the words were always the same: "It is one of the crying needs of Chicago and the country as a whole."

To me the problem of what to do about my mother, how to help her, had become an obsession. I thought there must be many others in a like situation. How could I reach them? What have they done about it? Perhaps together we could do much more than separately. The more I thought of it the more keenly did I see that the problem when multiplied by "many" was tremendous. The solution was indeed a crying need.

What could I do about the problem? Whom could I see about it? How does one go about making oneself heard? To consult anyone regarding my personal affairs required untold mustering of courage. For the first time in my life I had a situation on my hands I was at a loss

to handle alone, and the thought that my mother was the one to suffer by my hesitancy in consulting others about it spurred me on to some aggressive action.

So I started the rounds. I first asked doctors and friends. I then called and visited hospitals and spoke to the doctors in charge, personally. I went to many agencies; finally, to the charities. My pride was humbled, my self-assurance lost and the problem was still unsolved. *There was no place for the chronically ill.*

There were lonely places for the tuberculous, fine sanitariums for infantile paralysis victims, for children with heart disease, for crippled children, but no hospital would accept the unfortunate adult who in middle or late life had been stricken with paralysis, invaliding her, necessitating constant nursing care and leaving her with much time to think and wonder why she was left to live.

There is nothing more heartbreaking, not even the death of a loved one, than to watch that loved one slowly lose courage and hope. Nothing more pitiful to see than the look of fear come into her eyes. Cures for this illness, we know, are not as yet a part of the many miracles of medical science, but surely they must have a reason for living. God in keeping them alive must have a purpose. Should we not be responsible for keeping them filled with faith?

The Dream May Come True

I dreamed at night of a wonderful sanitarium filled with sunshine and growing flowers. I saw sun porches filled with wheel chairs occupied by mothers and fathers and sisters and brothers of someone, my mother included; all were busy with some sort of work, occupational therapy. I saw an experimental ward, a gymnasium for ambulatory exercises for those whose possibilities were greater.

I still dream about this wonderful place and since I spoke to you, Miss Nicholson, and discovered your complete understanding of this problem and realized that others also know of it and are working diligently toward a solution of it, I believe that some day there will be not one but perhaps many of these dream places for our beloved so-called chronically ill.

For your records, Miss Nicholson, I want you to know what the charities had to offer me:

1. **Old Peoples' Home.** But my mother was only 65 years old and looked 40, full of life and fun, not senile. She was only tied to a bed by a dead arm and leg. Her courage was fine; she was sure she would be able to walk again soon and was eagerly looking forward to tomorrow. How could she fit in with people in their 80's; would that be good for her morale? That was a place to go to wait for another stroke and death.

2. **Convalescent Home.** Its atmosphere was dismal and its rates were exorbitant. There were no facilities for occupational therapy whereby a paralytic of sound mind and one good arm and leg could learn to do something with whatever equipment she had left to her to make the day worth living through. Another place to lie and wait was all this home had to offer, and for a mighty price.

We are plain middle-class people. My husband earns a modest salary on which we have heretofore been able to live comfortably with a saving for the "rainy day" and for insurance for the "inevitable day." This unexpected tragedy of my mother wiped out her nest egg and threatened to engulf us financially, too.

My health and my husband's, after three years of caring for her, with the confinement of those three years and the constant nursing day and night (help was impossible to get for any length of time since war plants and hospitals needed all available women) began to fail. My husband developed high blood pressure and I developed arthritis with periods of much pain. We needed so much to be able to look after ourselves.

It was then that I began to look for a good place for my mother where she could be cared for and helped to create a life for herself in the scheme of things. We realized by that time that she had recovered as much use out of that leg and arm as she ever would and that was not enough for her to be able to walk by herself. It was then I found out that one had to be a pauper to get any assistance from the charities. If you were destitute, had no money whatsoever, they would graciously take your mother to the poorhouse; they take "chronics" there! Nice thought, wasn't it? They would also get your mother a "poor man's pension or assistance."

I was not looking for charity, I was not looking for any old place to dump my mother. I wanted to find a rehabilitation hospital of a sort, such as there is for the returning soldiers, where she could be taught how to live with her handicap and I wanted to pay for it. With her comfortably placed, not only would I be free to care for myself but I could provide the extra means it would require to take care of my mother's expenses.

They Wanted to Pay

Surely, there must be a place where the environment would be helpful to one's happiness and where she could speak to others similarly afflicted and indulge in competitive activity which would lead to accomplishment—and whose prices would not be prohibitive to people of modest circumstances. We felt we could manage $100 a month. Every convalescent home that was just *clean* wanted $40 to $50 a week, but more for a "chronic" if it should have a vacancy and could get help to care for her.

The nearest thing to real and tangible help I received was when I entered the office of the Association for Crippled People. I found there the steppingstone to what will one day be that place of my dreams. For there I found self-supporting handicapped people and I found that they, in turn, were teaching others. The association needs much more help from the community than it is getting to reach all the unfortunates who need help. There, I was given the address of the "Council for the Chronically Ill." I can never be able to thank you enough for the help you gave me and the encouragement you inspired me with.

Will this wonderful organization be the Guiding Star to lead us?

With much gratitude and sincere wishes for success in your endeavors.

Myrtle [Mrs. William] Sherman
6101 Sheridan Road
Chicago

General Hospitals Join the Fight to eradicate tuberculosis

M. POLLAK, M.D.

Superintendent, Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

A PHOTOFLUOROGRAPHIC x-ray unit was opened in connection with the admitting office of St. Francis Hospital, Peoria, Ill., on Nov. 26, 1945. Every patient from the age of 15 years upward admitted to the hospital will have an x-ray examination of his chest unless his condition contraindicates such procedure. Patients admitted in a serious condition will be examined by x-ray prior to their discharge. Because tuberculosis often simulates a pneumonia at its onset, pneumonia patients will be given x-ray tests also prior to their discharge, irrespective of whether they had such tests during their hospital stay.

The x-ray unit is located adjacent to the hospital admitting office so that the patients can be readily routed from this office through the unit to their respective accommodations in the hospital. Thus, Peoria's largest general hospital with a bed capacity of more than 500, which had close to 14,000 admissions in 1944, has joined, as it should, the ranks in the fight against tuberculosis.

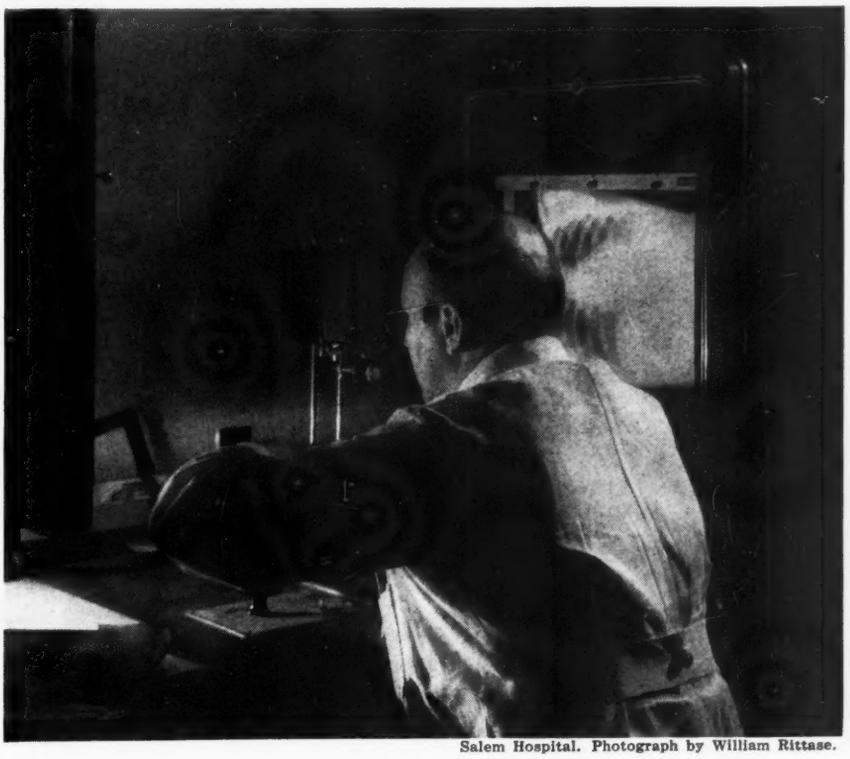
As has been often emphasized in the hospital literature by authorities in the field of tuberculosis control, the general hospital is in a strategic position to make signal contributions to the eradication of tuberculosis. Why? Because extensive surveys conducted in various parts of the country have shown that from 0.5 to 2 per cent of the patients admitted to the general hospital suffer from active pulmonary tuberculosis, and their disease is not detected unless the chests of all patients are examined by x-ray as a routine procedure. The discovery of a serious communicable disease like tuberculosis is essential not only to the patient but also to the hospital, its personnel, the attending physician and the community.

Such a discovery also protects the reputation and professional standing of the attending physician from reproaches on the part of the patients that their disease has been overlooked and neglected. And, finally, it is in the interest of the community that such a widespread communicable disease as tuberculosis is checked by all available means.

Since the beginning of organized efforts in the control of tuberculosis, great emphasis has been placed on the recognition of the disease in its early stages, when it is most amenable to treatment. Such efforts have proved illusive because neither the symptoms, which often appear only in the later stages of the disease, nor the ordinary methods of physical examination can be relied upon. With the advent of the x-ray a new and potent weapon for the early diagnosis of tuberculosis was made available. There were, however, two important factors militating against the widespread use of the x-ray.

1. Physicians in general practice still cling to the illusion that pulmonary tuberculosis must cause detectable changes in percussion and auscultation. They are loath to admit that their diagnostic acumen, of which they are proud, is not sharp enough to discover symptoms which the experienced phthisiologist knows are not present.

Phthisiologists who have had op-



Salem Hospital. Photograph by William Rittase.

All cases that show the need for further diagnosis after the initial examination with 35 mm. film will be examined with standard radiograms.

portunity to check their physical findings against x-ray films have long recognized humbly their human shortcomings. They know that extensive changes may be present in the lungs without the physician's being able to discover their presence by the time-honored methods of percussion and auscultation.

2. The cost of the conventional x-ray film is prohibitive for most patients. Even wealthy patients are resentful when they have to pay a significant sum only to find that their lungs are normal, and this is the case in most instances.

Thus, all the efforts to "have your chest examined by x-ray once annually' have led to no effective mass response. Because of the expense involved in the taking of the conventional 14 by 17 inch chest x-ray film, no community could afford such a mass x-ray survey. With the development of the photofluorographic units, however, such an undertaking has become entirely economical and within the reach of every community. As stated, hospitals particularly lend themselves to such mass surveys, because their yield in the discovery of active cases of pulmonary tuberculosis is relatively large and, thus, the cost per case becomes proportionately low.

These were the considerations which prompted the Peoria County Tuberculosis Association, the Peoria Municipal Tuberculosis Sanitarium, the Peoria County Tuberculosis Sanatorium District and St. Francis Hospital to join hands in the establishment of the x-ray unit. Recognizing the fact that the control of tuberculosis is a public health problem, the tuberculosis agencies accepted their obligation of combating the disease within the walls of the hospital.

The tuberculosis association purchased the equipment, the two tax-supported agencies finance the salary of the technician, the hospital provides the quarters and the hospital roentgenologist has made his services available free of charge. Under these conditions it has become possible to furnish this service without cost to the patients.

In deciding to establish a hospital unit the tuberculosis agencies had to chose among the three existing hospitals in the community because the financial means permitted the furnishing of only one unit at the present time. The decision, however, was made easy by the fact that the annual number of admissions in the hospital chosen was about one and a half times higher than the admissions to the other two hospitals combined. Plans are under way, however, to establish a unit in the second largest hospital in the near future.

Serious consideration was given to the selection of the type of equipment. Not only the cost but, more important, the time involved in the study of the films had to be considered because time is, after all, the most expensive factor because such study must be made by a trained radiologist. Roll films require the least time for their interpretation.

Because the films taken by the unit will be used for screening purposes only to select those cases that are in need of standard 14 by 17 radiograms for diagnosis, the use of 35 mm. films was agreed upon. In this selection consideration was also given to the fact that the unit should not enter into competition with the x-ray department of the hospital, which represents a considerable investment.

Aside from the expectation that through this unit at least 50 unsuspected cases of tuberculosis will be discovered in the course of a year, we have even more important reasons for looking forward to its service.

For many years the efforts directed toward influencing physicians in general practice to make wider use of chest radiograms for the early discovery of tuberculosis have, by and large, failed for the reasons given. We expect now, however, that the use of this unit will serve as a veritable postgraduate course in the diagnosis of tuberculosis to all physicians who use the hospital in any capacity.

Thus, we hope that the physician in general practice, on whom the success of every public health movement depends, will finally be reached effectively so that he will fill the rôle that only he can fill in the ultimate eradication of tuberculosis.

Flower Mixup Makes a Friend

A FEW months ago when a highly important meeting was being held at the hospital, I was called on the telephone by a very irate woman who stated that a week ago she had sent a bouquet of flowers to a friend of hers who was in the hospital and that it never had been delivered. She gave me the name of the patient, the name of the florist and the time the flowers were delivered, and she even had ascertained the name of the hospital employe who had received the flowers.

The next day a check was made upon this flower delivery, and it was found that there were two women in the hospital by the same name. The flowers, of course, were sent to the wrong woman, but to make matters more complicated when she opened the greeting card accompanying the flowers it was signed "Mollie." The patient had a friend named Mollie so she assumed that the flowers belonged to her.

The patient for whom the flowers were intended was then interviewed and to the amusement of everyone it was found that she also had a friend named "Mollie." Her friend, of course, was the Mollie who had actually sent the flowers.

The donor of the flowers was called, the circumstances were explained and an offer was made, even though the hospital could not possibly have avoided the error, to reimburse her for the purchase. She became quite agreeable and would not think of having the hospital pay for the flowers. She went so far as to say that it was her fault in that she should have signed her full name.

It is doubtful if it will ever happen again that the hospital will have two patients at the same time with the same name, each having a friend with the same name, one of whom will send flowers, thus permitting the recurrence of such an unavoidable error. However, by following through on this complaint the hospital made a friend instead of losing one.—LUCIUS R. WILSON, M.D., *superintendent, Hospital of the Protestant Episcopal Church, Philadelphia.*

You May Be Held Liable

for unauthorized disclosure of patients' medical records

EMANUEL HAYT
Attorney
New York City

IT IS usually necessary for the patient to give his physician all information having any bearing on his malady to enable the physician to administer the most helpful treatment. This may call for the imparting of information that may be both embarrassing and harmful to the patient if given general circulation. In recognition of this fact, statutes have been enacted in many states protecting the patient from disclosure of such confidential communications in judicial proceedings, except upon consent of the patient or by waiver of the privilege of secrecy.

May Be Sued for Damages

A physician may be held answerable in damages to his patient for injuries resulting to the latter from a wrongful disclosure on the witness stand of confidential information. However, a physician is not liable for disclosing on the witness stand information gained professionally if the testimony was admissible in the case and was relevant and pertinent to the issues, or if it was admitted by the court over objections made to its admissibility.[1]

The hospital medical records, as well as the information obtained by the physician while attending a patient, have the status of privileged communications; they should not be disclosed without the consent of the patient or a proper waiver.[2] The patient's medical chart, x-ray plates and photographs made by physicians in the course of treatment are confidential communications to the same extent as is the testimony of the physician who made the diagnosis. Without the required consent or waiver, information contained in hospital records showing the character of the disease or ailment of the patient may not be revealed.[3]

Privilege Is Qualified. A patient brought an action against a physician for betrayal of professional confidence and duty of secrecy. The physician had examined the patient and found him to be suffering from a communicable venereal disease. Feeling that the patient was a menace to others living in the same boarding house, the physician suggested to the patient that he move. Upon the failure of the patient to leave the premises, the physician notified the proprietor of the nature of the disease; the owner then compelled the patient to get out.

Although the patient actually was not afflicted with a venereal disease and the physician had made unauthorized disclosures to the proprietor, the court held that the information was not privileged. Although the information was confidential, it was subject to the qualification that if the disease was so communicable that it was likely to infect others in close proximity, the physician would be under a public duty to make such disclosure as would prevent spread of the disease. In such circumstances, if the physician acts in good faith, without malice, he is not liable for revealing the information even though he had made a wrong diagnosis.

This case, the court remarked, was a novel one and, ordinarily, would come under the statute, "a positive duty is imposed upon the physician, both for the benefit and advantage of the patient, as well as in the interest of general public policy. A wrongful breach of such confidence, and a betrayal of such trust, would give rise to a civil action for damages naturally flowing from such wrong."[4]

There are other instances in which the physician, as a matter of public policy, cannot be bound by the injunction of silence. He is justified in reporting certain communicable diseases; violent injuries, such as gunshot wounds; ophthalmia neonatorum; stillbirths; deaths and their causes.

An action is recorded of a patient against a physician arising from an erroneous diagnosis of smallpox, which caused the patient to be confined to the smallpox ward of the quarantine hospital. The jury found in favor of the physician, because it believed that the physician did what was proper in the case of a dangerous, infectious, communicable disease; that the physical evidences indicated to him, although mistakenly, that the patient was afflicted with such disease; that the physician was bound to report the facts to the public health authorities.[5]

Records of known or suspected carriers of communicable diseases, kept pursuant to the public health laws, are not privileged as a matter of public policy; the information is not acquired by the health official attending a patient in a professional capacity. Although the information may have come to the health officer from a physician in private practice, the transmission from that physician to the public officer is in obedience to the express command of a statute.[6]

Responsibility of Administrator. A recent case against the medical superintendent of a public hospital poses a number of interesting questions on the liability of a hospital administrator or record librarian for the unauthorized disclosure of hospital record information and suggests certain conclusions which are of interest.

While a patient was examining her own record in a state mental disease hospital she discovered a letter from a physician member of the board of visitors requesting the medical superintendent of the hospital to send him a summary of her medical record. The information was for a lawyer who claimed that

[1] American Jurisprudence, Vol. 41, sec. 75.
[2] Rush *v.* Metropolitan Life Ins. Co., 63 S.W. 2d 453 (Mo.).
[3] Lorde *v.* Guardian Life Ins. Co., 252 App. Div. 646, 300 N.Y.S. 721.
[4] Simonsen *v.* Swenson, 177 N.W. 831, 104 Neb. 224.
[5] McGuire *v.* Amyx, 297 S.W. 968 (Mo.).
[6] Thomas *v.* Morris, 286 N.Y. 266, 36 N.E. 2d 141, 136 A.L.R. 854.

the patient was suing his partner's estate.

The superintendent replied to the physician and enclosed a summary statement showing the chronological incidents of the patient's sojourn in the hospital, her personal history, the nature of her mental and physical ailments, the diagnosis and treatment prescribed and similar pertinent facts. There was nothing to indicate, however, that the information was communicated by the physician to the lawyer.

Thereafter, the patient instituted an action against the medical superintendent for a violation of the Mental Hygiene Law, for a violation of the statute prohibiting disclosure of confidential information and for libel. A motion was made by the medical superintendent to dismiss the three causes of action in the complaint or, in the alternative, to strike out certain of the allegations.

Granting part of the motion, the court held that where a statutory duty is violated the patient is entitled to redress, for where a positive duty is imposed by law, a breach of that duty will give rise to a cause of action for damages by the person for whose benefit the duty was imposed.

The Mental Hygiene Law provided that it is the duty of the director or other person in charge of the hospital to make, or cause to be made, a descriptive case record of the mental state, bodily condition and medical treatment of each patient. Except on consent of the commissioner of mental hygiene or an order of the court, "such record shall be accessible only to the director and such officers or subordinates of the institution as he may designate and to the commissioner and his representatives."

This statute makes the contents of case records privileged communications and imposes a duty upon officials of the institutions not to make the records available except in accordance with the statute. Its primary purpose, said the court, was to prevent officials of mental disease institutions from disclosing information imparted for the purpose of care and treatment, and thus save patients from humiliation, embarrassment and disgrace. The complaint therefore set forth a valid first cause of action for violation of the statutory duty.

However, the second cause of action, based on the statute that forbids physicians from disclosing information acquired in a professional capacity, had no application to the present case. That statute applies only when the relation of physician and patient exists. There was no such relationship between the patient and the superintendent. Hence, the second cause of action was dismissed.

The third cause of action for libel was stricken out because the claim was barred by the one year statute of limitations. This action should have been commenced within one year after the sending of the letter disclosing the information contained in the record.[7]

[7]Munzer *v.* Blaisdell, 49 N.Y.S. 2d 915.

Clinic Care *at the Semiprivate Level*

FRANK E. WING

Director
New England Medical Center
Boston

HOW will out-patient services adjust themselves to the needs of the postwar period? Who will be their customers? What will be the staff relationships? How will clinics be supported?

These are some of the problems that are disturbing hospital administrators, doctors and others closely concerned with out-patient work. These and similar questions are prompted by the prospect of dwindling volunteer support, by the changing attitude of government toward medical care, by the shortage of doctors who can give their time to voluntary clinic services and by the effect of war-time employment on the family income of a large segment of their former clinic clientele.

The few observations made hereafter are intended to challenge our thinking to the need of planning for out-patient work in its relation to the future distribution of medical care for ambulatory patients. To get an over-all view of the situation that voluntary clinics are facing at the present time, let us direct our thinking from each of seven different angles of approach.

1. If present trends continue, the near future will see full responsibility for medical care of the indigent assumed by government. In proportion to the extent to which this burden is actually carried by governmental agencies, the free work heretofore done by voluntary clinics will be released or, if continued, will be supported by tax funds. To the same extent, community chests and other channels of private philanthropy will be relieved of the burden of support they have heretofore carried.

As a further result of this shift of financial responsibility, doctors who traditionally have given freely of their time and services to clinic patients unable to pay private office fees will be put on a moderate salary basis.

2. Prepayment medical care plans, whether compulsory or voluntary, will seek channels through which their subscribers or beneficiaries can obtain medical care. It does not necessarily follow that all such medical services will be supplied through the medium of private office practice.

3. Since group practice is admittedly of higher quality and more economical than is private office practice, there is a strong probability that part of this prepaid medical care will be supplied by doctors working in groups. There is no valid reason why, in the exercise of their choice of physician, members of prepayment plans should be denied the right to select voluntary clinics, instead of privately organized group clinics or doctors' private offices, in which to obtain their medical care provided the doctors working in those voluntary clinics are allowed to share in the fees established for such service.

4. Labor organizations and industry are coming to recognize the advantages of a health program for their members and employes. Industrial medicine is fast going beyond the preventive stage and is offering plans extending into the field of medical care. Employers and employes are looking to organized group practice as the most efficient medium for obtaining the health and therapeutic benefits they require.

5. The public is fast coming to understand, as most doctors will privately admit, that under the present system of private office practice the American people are not getting an adequate return for the amount of money they spend for medical care. The reason is not that the service is of low quality but that it is uneconomically organized and wastefully distributed.

Multiplicity of separate specialists' offices, streamlined waiting rooms, heavy investment in highly specialized equipment, consulting rooms occupied only two or three hours a day and idle while the doctor spends the rest of his day in hospitals or medical classrooms, heavy rental or capital building expense, all impose a huge overhead that must be passed on to the private patient, perhaps doubling the size of necessary consultation fees.

Must Refer Patients to Specialists

Developments in medicine have become so highly diversified that no individual can cover the whole field; hence the necessity of referring the patient to numerous consultants. These consultants frequently have offices in separate buildings and, of necessity, work on the appointment system with the result that the time necessary to obtain the opinions of several specialists may extend over a period of one or two weeks.

These difficulties usually adjust themselves for patients of ample means but, for the average family doctor and the average patient, consultation services are more satisfactory and more economically rendered when they are supplied by a group of doctors working with centralized facilities under the same roof.

6. Hundreds of physicians are coming back from military service with changed ideas as to how they are going to practice medicine in the future. Thousands who have never practiced in civilian life are going to want a period of from one to three years of supervised experience in hospitals and clinics before setting up business for themselves.

In their adjustment back into civilian practice, many will be attracted to the advantages of group practice. They will welcome the opportunity to work on a half-time or a full-time basis, on adequate salaries, as members of organized clinic groups. This will be particularly true if the clinic groups are organized to offer opportunities for graduate instruction and educational advancement.

7. The hospitals of this country have a huge investment in buildings and equipment. In the large majority of hospitals, the out-patient services are open only half of the day, either in the morning or in the afternoon, and consulting and examining rooms are lying idle during the other half of the day and in the evening. Clinical laboratories, x-ray departments and other diagnostic facilities could be expanded at relatively small expense to handle a larger load. All that are lacking for an eight to twelve hour use are more doctors working half or full time, additional nonmedical personnel and the raising of the admissibility level so that more patients can be served.

By this time, the reader will have gained an inkling of the suggestion that I am now going to put into more concrete form. The proposal is that out-patient services in various parts of the country, preferably in hospitals or dispensaries affiliated with medical schools, try the experiment of organizing their staffs on a group practice basis and that they proceed to admit patients of moderate means for diagnostic studies and special consultation services at the semiprivate level.

A plan thus organized could easily be extended into the field of treatment for members of prepayment plans and industrial groups who, in the exercise of their right to choose a physician, might wish to select the clinic as the means through which to receive medical care. The extension of such a plan involving the utilization of heretofore unused space during nonclinic hours would make it possible to offer former service men and young physicians opportunities to gain additional experience during the period of adjustment into private practice.

Many hospitals and clinics have already made considerable advance along these lines in offering diagnostic studies and specialized consultations to outside practitioners for the benefit of their private patients. These studies are made at a price level which makes possible the sharing of the fee on a point system with the internist and any specialists who may be called in consultation. The report of findings is sent to the referring physician. No treatment is given. In diagnostic cases, if the patient has no physician, he is assisted in selecting one whenever treatment is advised.

Medical Center Has Plan

For many years, the Boston Dispensary, to a limited extent, has been offering to patients of moderate means such services as have been described in the preceding paragraph. In recent years, similar opportunities have been offered to patients of the higher income levels by Joseph H. Pratt Diagnostic Hospital, which is also a unit of the New England Medical Center.

Physicians and patients alike agree that these have been useful and satisfactory services. Through them, four-fold benefits are derived.

The referring physician is helped because he obtains a service that he needs and, through it, is able to continue treatment of the patient under his private care.

The staff member is helped, particularly if he is a young physician or a veteran in need of additional supervised experience, because the arrangement not only gives him such experience but also supplies him with an income.

The patient is benefited because, at a saving of both time and money, he has the advantage of the services of a group of well-trained specialists working together with excellent facilities.

The hospital benefits because of the prestige it acquires in performing a wider public service and by the fact that the fuller use of its plant for pay clinics tends to reduce the overhead chargeable to free service.

Industry and Hospitals Have Similar Aims *in Their Personnel Relations Programs*

NORMAN D. BAILEY

Personnel Director
Michael Reese Hospital
Chicago

THE transition from the field of industrial personnel to that of institutional personnel involves certain changes in approach to the problems of the personnel office. I came to Michael Reese Hospital, Chicago, with a dual attitude of mind. First of all, I am a layman. As a layman my attitude toward hospitals was somewhat hazy and had as its background infrequent calls upon friends who had been hospitalized, a brief hospitalization experience of my own and a somewhat remote experience in some waiting room for prospective fathers.

My other point of view was based on specialization in personnel work which has given me the belief that the fundamental elements that work with institutional personnel are in most cases the same as those that affect industry. True, indeed, is the statement that "service" as a motive must be constantly stressed in the hospital. Also true is the fact that no longer can industry say "there is a war on." Industry must realize that as market conditions become increasingly competitive the service motive will gain in importance in all phases of industrial activity.

Questions Lead to Goals

From the industrial field come certain basic personnel concepts, among these efficiency of operation, importance of useable records, need for training and indoctrination programs even for nonskilled groups, motivation of production through incentives. As I made a preliminary survey and attempted to take stock of my experience in its relation to the new work, I found myself asking certain questions that may well lead to the choice of goals for action.

1. Are the personnel records adequate enough to give a ready picture of each employe? If not, what records would be desirable in the institutional personnel office?

2. What procedures are followed for indoctrination and training of nonprofessional employes? Are these procedures perfunctory or are they organized with the view of instilling not only work regulations but also service ideals?

3. Turnover at semiskilled and unskilled levels in hospitals, as in industry, has been far in excess of the figure necessary for efficient operation. What are the underlying causes of this turnover? What is the turnover costing (a) in service rendered, (b) in financial outlay, (c) in public attitudes, (d) in hospital morale?

4. Along with turnover goes the whole problem of absenteeism. What factors enter this picture? Are there any that could be eliminated by more careful preemployment screening? Is it possible to provide other remedial measures?

5. Are job specifications available in sufficient detail to make preemployment screening and interviewing effective in reducing job dissatisfaction?

6. Is there any program of preemployment aptitude testing that is applicable to employment procedures at nonprofessional levels? What are the bases for decision on the aptitudes of prospective employes? Industry knows, for example, that there are ranges in intelligence which set upper and lower limits for job happiness and job success. Can ranges be determined for certain tasks at nonprofessional levels in hospitals? What other test criteria can be applied?

7. Does the wage incentive program apply in any way to the nonprofessional hospital employe? At first glance it would seem that there is no place for an incentive program in any employment directly affecting patients. Since the basic principle of the incentive is to provide increased remuneration through increased production at no increase in unit cost one may well ask whether there is a place for the program and resulting job satisfaction. Is there some other motivation that would attain desired ends equally well or more advantageously?

8. In the past few years industrial personnel has become increasingly conscious of and attentive to services which can be classed under the general heading of "employe welfare." To what extent can institutional personnel programs meet these needs?

Out of these questions will arise many more. Some will be answered. Many will call for research and thorough study over a considerable period of time. I plan to follow this article a year from now with a second one written in the light of my experience with the work of the hospital personnel department.

Seek Best Adjustment

The goal of all personnel work, industrial or institutional, is the best possible adjustment between the employe and the job. This best adjustment is attained only when there is a well-placed employe who is happy at his work and who gives adequate return to the employer.

In facing a postwar world, institution and industry alike must provide service, for a postwar world not only will demand from industry an acceptable product and from the institution excellent professional care but will call for service. Through service will come that public recognition which means sales to industry and public support to the institution. To a program of employe selection and training with the end in view of rendering the finest service possible within the given limits of cost, all personnel officials, institutional or industrial, must stand committed.

Collections Do Them Credit

Collection experience of many hospitals confirms the old adage about catching more flies with sugar than with vinegar

PICTURE for a moment an interview between the credit manager and president of a department store, say, or an electric light company. They are going over the outstanding accounts that remain on the books at the end of the month. The credit manager is making his recommendations:

"Now, take this $60 account of Anderson's," he is saying. "I don't think we ought to bill Anderson again this month. Pretty tough time they're having at his house—maybe you know about it. Daughter and her husband living with the folks until they can find a place of their own. Youngster's been sick. Anderson himself was laid off for a month or so down at the factory when they shut down that time, right after the war ended. Yessir, I think we ought to move this one up a few months, until those people get on their feet a little better. Anderson's a good man; he'll pay when he can. . . ."

If he ever got to the end of that report, the credit manager would probably find himself out of a job. Grossly incompetent, the boss would surely think, or soft in the head, or both.

That Is What Hospitals Do

Yet there is one important business in nearly every community that takes precisely this attitude toward many of its outstanding accounts. The humanitarian purposes for which hospitals are organized and operated are reflected in business methods that often differ sharply from those generally employed in commercial enterprises. A Small Hospital Forum on hospital credit and collection practices reveals that three fourths of the hospitals queried differentiate in their collection methods between families able to pay their hospital bills and those for whom the bill is a known financial hardship. Where business often bears down hardest to collect its bills, most hospitals take it easy.

This policy is consistent with the nature of the hospital's work. Besides, in the opinion of one man who has had twenty years' successful experience collecting hospital bills, it is the best possible way to make sure of collecting the full amount of the hospital's charges.

"People are sensitive about the bills they owe," this man says, "and they are quick to take offense at any imagined insult in a collection letter or telephone call. Once a person gets angry, justifiably or not, your chance of collecting your bill just about disappears.

"On the other hand," he goes on, "nearly everybody responds to kindness and consideration. Why, we've collected in full from people who owe bills at every store in town, simply by assuring them that there was no hurry about payment. As a matter of fact, while there are a few deadbeats in every community, I believe that most people do want to pay their bills and ultimately will unless they're antagonized. The number of people who come to the hospital—sometimes years later—to pay up old balances that have long since been written off and forgotten is a constant source of astonishment to me."

Bad debt write-offs among the hospitals responding to the forum range from 1 to 5 per cent of total billing annually. One hospital reported happily that there was "no write-off at all," and another gloomily acknowledged a 20 per cent loss, but it seems likely that these answers represent differences in accounting practice or terminology rather than in actual collection experience.

All but two hospitals reported that credit losses had diminished during

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
Hotel Dieu de St. Joseph, Tracadie, N. B.	Sister St. Stanislas	28
Scripps Metabolic Clinic, La Jolla, Calif.	W. C. Crandall	35
St. Mary's Hospital, Russellville, Ark.	W. R. Pate	50
Community Hospital, Medford, Ore.	Phyllis Swearingen	52
Lincoln Hospital, Detroit	Evelyn Leitner	58
Memorial Hospital, Catskill, N. Y.	M. J. Mapes	60
Vicksburg Hospital, Vicksburg, Miss.	John F. Barker	65
St. Mary's Hospital, Enid, Okla.	Sister M. Alicia	75
Mennonite Hospital, La Junta, Colo.	Wesley Jantz	75
St. Lucas Evangelical Deaconess Hospital, Faribault, Minn.	Rev. W. Merzdorf	79
Miller Memorial Hospital, Duluth, Minn.	Frances Eckman	83
Windham Community Memorial Hospital, Inc., Willimantic, Conn.	W. B. Sweeney	100
University Hospital, Chicago	L. Swing	100
Whidden Memorial Hospital, Everett, Mass.	Evelyn G. Morgan	100
Protestant Hospital of Nashville, Inc., Nashville, Tenn.	Lois B. Stow	110
Mount Sinai Hospital, Toronto, Ont.	Dr. S. G. Fines	110
Lutheran Hospital, Fort Dodge, Iowa	O. A. Rusley	120

the war, reflecting generally high conditions of employment and financial security in most communities. War-time improvements in credit experience varied from "slight" in a few cases to several reports indicating that losses had practically disappeared. Probably the average of the responses would indicate that credit losses have been cut in half during the war period. This may be proof that people do want to pay their bills when they can, as the correspondent quoted earlier believes.

Five of the hospitals participating in the forum ask for an advance payment from every patient at the time of admission. All the others ask for payments in some instances but extend credit in others. The basis for selecting those to whom credit privileges are offered is varied. In several cases payments are sought unless the patient has Blue Cross or other hospitalization insurance.

Doctors Know Credit Rating

Many hospitals use the local credit bureau, merchants' credit association or bank. Some depend on the doctors for credit information (and they should know!). Several hospitals in smaller communities report that they give a pass to everyone they know and require advance payment only from out-of-town patients; many add that they already are familiar with the credit standing of all except the occasional emergency case from out of the area.

Opinion is divided as to whether the effort of writing individualized collection letters is worth while. Several administrators report that they have given this method a thorough tryout and then reverted to sending only a monthly statement on slow accounts, because the results of individual letters simply did not justify continuing to take the time to write them.

Other administrators, however, are just as sure that the letter written to suit the case is the one that gets the money. A few procedures include telephone calls or even personal calls, after statements and letters have failed to produce action in a reasonable time.

The ultimate destination of the unpaid account is the collection agency. All except two of the reporting hospitals use an agency service once they become convinced that their own efforts to collect the bill are failing, a point that occurs in some cases when the bed is barely made for the next patient and in others as much as two years later. Specifically, of 17 hospitals replying to this question, one uses a collection service for all accounts not paid at the time of discharge; four turn over accounts that remain unpaid after sixty days; one, at ninety days; four, at six months; six, at one year, and one, at two years.

Of the two hospitals that do not use any kind of collection service, one just keeps on sending letters and hoping for the best until it is clearly time to write off the account. The other institution claims it doesn't have any need for collection agency services; instead, a reserve of 4 per cent for bad debts is set up on the hospital books and considered as part of the operating budget. This is adequate to cover all losses, it is stated, and no time or effort is spent trying to collect the uncollectible.

The same hospital offers a cash discount plan for paying patients; those who pay on admission and weekly thereafter in advance receive a discount of approximately 5 per cent on the ward rate, though the discount is stated in each case in dollars and cents rather than in a percentage: "The flat figure has a better, and quicker, appeal," the administrator states. There is no discount on the charges for extra services, which are billed when the patient leaves the hospital.

The overwhelming majority of the hospitals in this group welcome Blue Cross and other forms of hospitalization insurance. Only one hospital answered "no" to the question: "Has Blue Cross or other hospitalization insurance made a great difference in the ability of your community as a whole to pay hospital bills?" Another hospital reported that Blue Cross was just getting started in the community and had not had time to make itself felt as an economic force.

All the rest answered with an enthusiastic "yes." Many added comments of their own. "Blue Cross makes collections easy," said one. "Helps by making possible more immediate payment in full of the hospital account and, consequently, greatly cutting collection expenses and revenue tied up in accounts receivable," another reply explained.

These and other answers leave little doubt that hospitals are sold on Blue Cross as an aid to hospital operation as well as to the individual family needing protection.

VOLUNTEER ACTIVITIES

Eight Months—850 Members

The merry month of May is not far off and with it will come the first anniversary of the woman's auxiliary of Community Hospital, Geneva, Ill. In the first eight months of its existence, the enthusiastic women of Geneva and its surrounding area have run the membership up to the astounding figure of 850 members.

What worries the officers just now is where in the Fox River Valley they can find a dining room large enough to accommodate 850 women since the plan is to have an annual luncheon near the anniversary date, May 12.

Already it has been necessary to break up the auxiliary into seven regional units. The chairmen of these units meet with the executive board and act as liaison officers between the group as a whole and the smaller units.

Last fall the auxiliary held a benefit day at which it raised $3043. This came in about equal parts from three sources: combined unit projects, sale of chances and the percentage of sales made on that day at a local antique store and a bookstore.

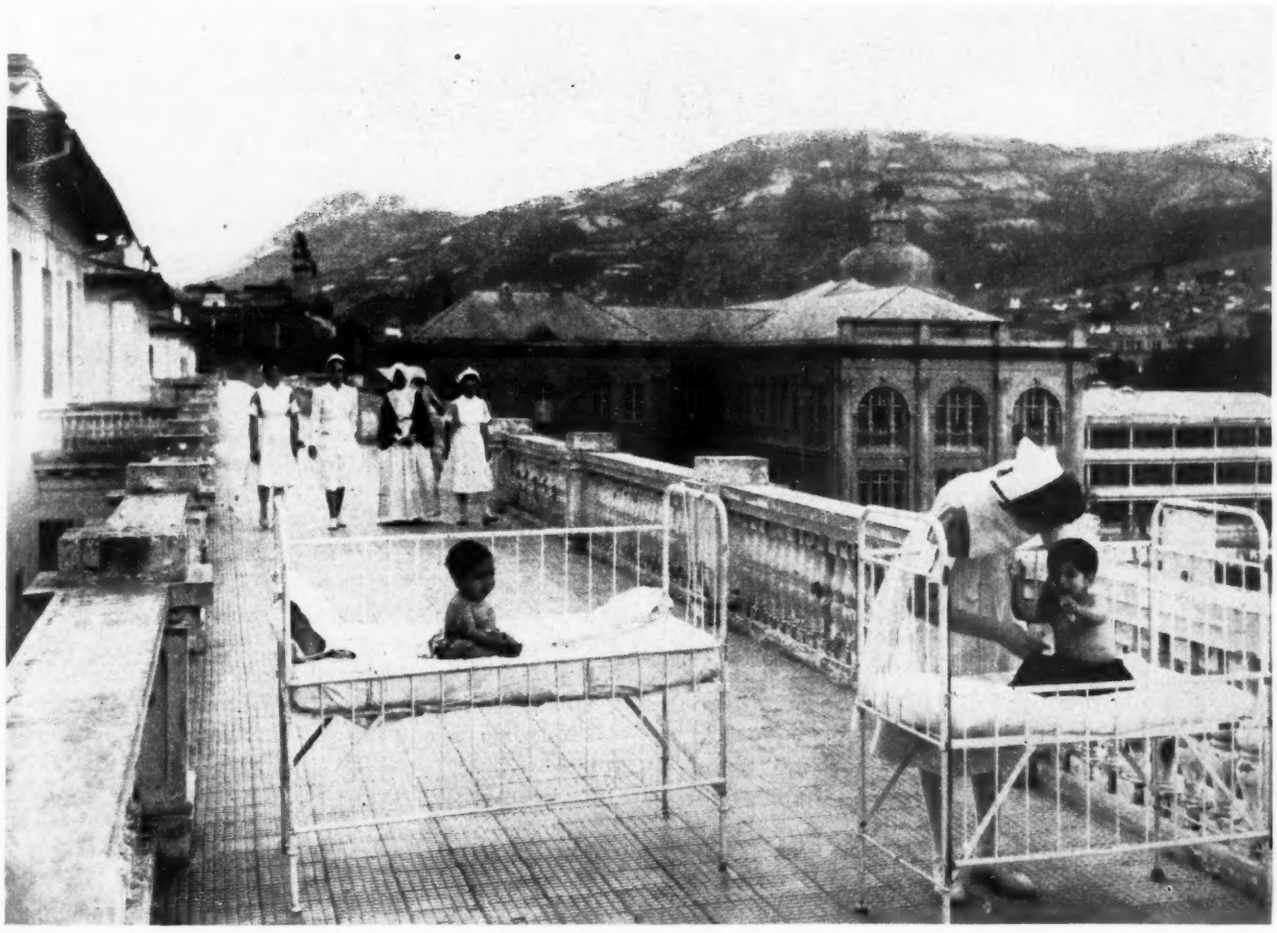
The organization in its first year has purchased 16 bassinets for the hospital and will refurbish the reception room to bring it into greater harmony with the rest of the building.

The Hours Mount Up

Their war-time service over, 1983 men and women and junior volunteers of the New Haven unit of Grace-New Haven Community Hospital, New Haven, Conn., recently received certificates, bars, smocks and thanks from the hospital.

Thirty-four women were given special service bars signifying the completion of from 500 to 4000 hours of volunteer work. As against a total of 181,808 war-time hours furnished by 1685 women, 35,944 hours were given by 208 men. Ninety juniors gave 39,000 hours.

At the ceremonies the hospital unit was careful to point out the continued need for volunteer service.



Kathleen Logan, director of the new nursing school, strolls down one of the hospital's long walks with Mother Justina and two students. In the foreground, another student attends to the needs of a young patient.

Reorganizing a Nation's Hospitals

HERMAN J. GRIMMER JR.

Hospital Administrator
Division of Sanitation
Institute of Inter-American Affairs
Quito, Ecuador

MY WORK in Ecuador as a hospital administrator charged with reorganizing all the hospitals is tied in with the work of the Institute of Inter-American Affairs in that country. I must, therefore, first place the Institute as an agency originally set up within the Office of Inter-American Affairs. The Institute, among other activities, has worked with the ministries of health in 18 Latin-American countries in stepping up public health facilities and services within those countries. The work in each case is based upon an agreement between the host country and the United States government.

Ecuador signed the first of these public health contracts in February 1942, agreeing to contribute money, goods and personnel for the program within its borders.

At the end of a year in Ecuador, the staff of the Institute was gratified to receive a special request from the *Junta de Beneficencia,* which may be translated as a board of welfare, for help in reorganizing the hospitals of the entire country. The *junta* asked particularly that the Institute locate a hospital administrator to take charge of the reorganization and I was assigned to do the job.

The task of reorganizing all the hospitals of a country is enough to bring confused dreams to any hospital administrator. For a beginning, we narrowed our task down to one hospital in the city of Guayaquil and planned to make that hospital a model in equipment and administrative methods and a guide for other hospitals. The General Hospital, with 700 beds, was selected.

This hospital, a charity institution, is supported almost entirely by contributions from the board of public welfare. These monies come mainly from weekly lotteries, local taxes and an annual allotment from the Ecuadorian government. Separated from the General Hospital, but coming under its administration, was a 120 bed tuberculosis and cancer hospital. A new 288 bed tuberculosis hospital was under construction to which the tuberculous patients would eventual-

ly be transferred. For the present, we transferred all the patients from this unit to the General Hospital proper and made a public bonfire of the old annex. We did this to symbolize in dramatic fashion the beginning of a new era of care for the tuberculous.

The General Hospital of Guayaquil has been in continuous operation for some fifty years. Besides the administration or main building, laundry, main kitchen and two wooden buildings used for semiprivate patients, the main hospital plant consisted of nine concrete buildings, with a total of 18 wards. Services rendered included medicine, surgery (all branches), genito-urinary services, gynecology and ophthalmology. Maternity cases were not admitted. Children under 12 years of age were not taken. Ear, nose and throat cases were mixed in with medical or surgical. Venereal disease cases were scattered throughout the hospital.

The professional personnel consisted only of physicians. Trained personnel had worked with some physician or surgeon for some years and could follow his procedures but were lost with a strange doctor. For the most part, the nonprofessional personnel consisted of bare-footed Indians, supervised by one Sister.

Situation Called for Tact

The two and a half years following my arrival in Ecuador were as interesting as any I shall ever live. Of course, they were packed with headaches. Any administrator who has ever had to reorganize a hospital knows that. But he cannot guess their number and severity unless he has had the experience of stepping into a strange country to reorganize the hospitals there. As a *Yanqui* I was obliged, of course, to be many times as tactful as would a native son called in to do the same job. Visiting *Yanquis* who have felt superior to things that seemed to them obsolete or inefficient or just different have built up considerable ill will for us all in Latin America.

During my first two months in Ecuador I studied the physical plant and administration of the hospitals. I found that hospitals in Ecuador never had administrators or executive heads. They are headed by a medical man who is called the medical director. He is usually the chief surgeon and, in addition, has charge of one of the principal surgical wards.

Under the medical director but, as far as I have been able to ascertain, on a par with him, come the physicians and surgeons. Each one is the administrator of a ward and has a life tenure on it. Every man's ward is his castle and if he wishes to carry out policies in direct contrast to those of the man in charge of the next ward, that is his privilege.

So it follows that in a hospital such as the General Hospital of Guayaquil, in which we have 18 wards, we have 18 administrators. To establish some general over-all policy for the wards, I had to get the approval of 18 men, then the approval of the medical director and finally had to bring the new policy to the attention of members of the *Junta de Beneficencia* or to some special committee. I had to remain on cordial terms with everyone involved and, even with all relationships working smoothly, would need weeks to get some policy approved.

One of the greatest detriments to the progress of reorganization was interference. This added to the difficulties of reorganizing hospitals in a strange land and through the medium of a foreign language. Every person who had any remote connection with the hospitals wanted his pet idea or theory put into practice. As an advisory administrator, I could arrive exactly nowhere. I talked over the obstacles with the *junta* and the doctors and was appointed administrator in fact.

First, we drew up a set of rules and regulations defining the duties and rights of the administrator and making it clear to all concerned that they were to be followed through to the letter. The policy stipulated that the administrator would not tolerate any political interference, internal or external, in the administration and reorganization of the hospital. This stipulation put some firm ground beneath my feet.

Changes in the administrative and medical policies were undertaken little by little and as unobtrusively as possible. New methods were slipped in here, new procedures were added there. When a new procedure was proposed, an alternative was also offered, both clearly defined and based on local conditions. Reasons were given as to why one method might not work as well as the other. It was not considered good policy to try to establish a new method without having another at hand in case the first turned out badly.

Getting rid of some of the older buildings aroused some opposition because they were built as memorials or for other reasons of a traditional nature. In every case, when a building was torn down a replacement was planned. The building program sponsored through the Institute of Inter-American Affairs included two new pavilions for General Hospital, totaling 90 beds. These two new buildings helped greatly in the physical reorganization of the hospital.

Wards Grouped Together

The services and wards were rearranged. Whole wards were transferred from one section to another. Now all medical cases are in one group of buildings, surgical cases in another group. One building is used for eye, ear, nose and throat, a new service. The hospital did have an eye service which now has its own special operating room, out-patient clinics and modern equipment for diagnosis. The ear, nose and throat service has its own facilities. Both services are under the direction of competent specialists.

Two newly converted wards are reserved for the development of an orthopedic service and the scattered orthopedic cases have been brought together from all corners of the hospital. An Ecuadorian doctor is now in the United States completing a year's specialization in orthopedics and he will have charge of this service on his return. Candidates for scholarships offered through the Institute of Inter-American Affairs are selected with the idea of providing qualified physicians to have charge of the services in the reorganized hospitals.

We plan to have a cancer service and one physician has just completed a year's study in an outstanding cancer hospital in New York. Obviously, deep therapy should not be included without a qualified roentgenotherapist to take charge of the service.

With the coming of new buildings, new facilities and equipment, new standards of procedures fall into place. They do not seem drastic in the renovated surroundings and everybody is willing to use new procedures in the changing scene.

Likewise, the acquisitions made possible changes in the diagnostic facilities of the hospital and the administrative changes that went with them. The old x-ray machine was discarded and new modern apparatus was purchased. The installation of this new equipment will necessitate many physical changes in the department, and with the inauguration of this modern apparatus will come a change in professional direction, new methods and regulations for the operation of the department. It involves the training of lay technicians, never before used in Ecuador, and a definite change in medical and administrative policy. In the clinical laboratories, also, physical changes made possible administrative changes.

New Kitchen for Old

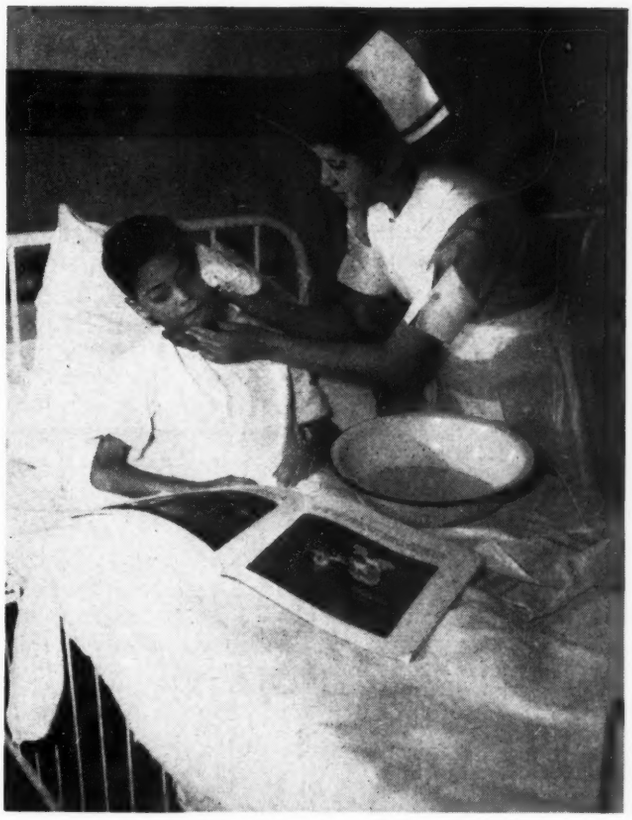
The old main kitchen, blackened within by years of grease, oil and smoke from wood-burning ranges, with no screening, no toilet facilities, no separation of work within the kitchen, was practically razed with the exception of the original floor and walls. The roof was heightened and the building was extended. Floors were tiled, walls were white-tiled, the building was screened, storerooms were added and the kitchen was partitioned for special types of work.

A washing room for pots and kettles is now a separate unit which will include electric dishwashing facilities. Refrigeration has been ordered. A meat-cutting room is in operation and, what is of great importance, the wood-burning range has been converted to automatic oil-burning equipment.

Toilets and dressing rooms for employes were installed. Employes must all bathe and change to kitchen clothes before beginning their work. All employes are examined for venereal disease and tuberculosis.

The kitchen is now kept spotlessly white. There is more time to spend on dietary matters. The food is better and there is more of it.

One administrative change that had to be effected independently of physical changes was an intern organization. Much discussion took place, reports were written up and a blueprint was drawn up of an intern organization that could be applied to local conditions necessary for the hospital and the medical course at the university. Finally, the medical director, the hospital and the *junta* agreed on an intern organization that conforms closely to standards set forth by the American Medical Association, the American Hospital Association and the American College of Surgeons. This intern organization will be set up and put into operation in the hospital in the near future.



Small boys in Latin America are no more enthusiastic about having their faces washed than are their brothers up in North America.

Nursing School on Sound Basis

The new National School of Nursing at Quito, which was sponsored jointly by the Institute, the Rockefeller Foundation and the Pan American Sanitary Bureau, is now on a sound basis and is receiving more and more applications for admission. The first group of three year graduates is now out. We are proud of the new school and are counting upon its graduates to supply modern nursing care in the new hospital system. They are necessary in fact to the success of the remodeled hospitals and the new hospitals.

The question of medical personnel I have left to the last and with good reason for it is a big problem and one that will take years of working out. There are doctors available, but no system is followed in selecting them. Usually, a doctor chooses some likely person and trains him according to his own ideas. This makeshift can in no way be considered a professional basis for selection.

For the administration of hospitals, we already have one well-qualified Ecuadorian who has worked with me for the last two years at the General Hospital as assistant administrator. He is doing a fine job and is enthusiastic over this profession. The *junta* allowed him to attend the International Institute for Hospital Administrators in Lima in 1944. The Ecuadorian government sent eight other men, all physicians, to this course and they returned to Ecuador with new ideas as to what hospital administration meant.

More Interest in Administration

Hospital inspectors are asking questions and seeking advice on administration. Government officials are showing a decided interest in the subject and doctors in general are enthusiastic. We have had requests for permission for men to come to the General Hospital in Guayaquil to observe and study. We welcome such men and hope eventually to institute some sort of refresher course. I have been asked to visit some towns and give short-term courses, and while these would not

be adequate to the subject they might stir local interest.

We hope shortly to be able to begin a training course in laboratory technic at the General Hospital in Guayaquil and are seeking a well-qualified laboratory technician to come to Ecuador to open the course. At present we have one Guayaquil radiologist who is willing to accept two men or women to train as x-ray technicians for the General Hospital.

The task of reorganizing all the hospitals of a country has so many ramifications that one can do little more than give a synopsis in an article of ordinary length. I have tried in this synopsis to present an idea of where we started and where we are heading. As I have been at pains to point out, the cooperative health work sponsored by the Ecuadorian government and the government of the United States is providing facilities and personnel that make the reorganization possible.

I sincerely hope that this cooperative work will be continued until we are certain that some of the ideas and institutions we have sponsored will endure. Certainly, this cooperative program for bringing medical science to the aid of more people represents one of the best types of internationalism that the world has ever seen.

Color Scheme

for the comfort of the convalescent

HARRY HYMAN
Superintendent
Rest Haven for Convalescents
Broomall, Pa.

SULFA drugs, penicillin, shadowless lighting, air-conditioned operating rooms, these are some of the benefits medical science has recently made available to us. Along with such life-preserving factors, the modern hospital keeps step with color therapy.

We used to think white was the color for a hospital and the widely used term "hospital white" was synonymous with cleanliness, sterility—and drabness. But today we are beginning to understand that colors have a definite effect upon the mental and physical states of all people. Colors, correctly used, cheer our spirits and sense of well-being; colors, incorrectly used, depress us. If tones and tints impress well persons, why shouldn't they impress those who are ill, perhaps to an even greater degree?

The modern hospital, therefore, now utilizes yellow, blue, green, violet and even orange and red: first, because the right color for the right purpose has a beneficial effect upon the brain and the nervous system; second, because color can be used to improve the appearance of the hospital, encouraging confidence and trust, and, third, because the hospital is a permanent home for its staff of professional workers, whose efficiency increases when they are provided with living quarters that promote comfort and happiness.

All of this suggests a definition of color therapy: Making certain colors perform certain functions is the purpose and meaning of color therapy. Yellow, for example, suggests sunlight and so has a cheering effect. Green suggests nature and has an almost universal appeal.

The hospital may be keeping step with modern knowledge by recognizing and using color therapy. But imagine, if you will, the feelings of the patient who has just been discharged from such a hospital. He is cured of his illness but still needs a period of perhaps several weeks for rest and relaxation before he can resume his normal way of living. So off he goes to a convalescent home.

Here the picture is quite different from that of the hospital. (We are speaking of many of the convalescent homes now in existence. There are exceptions, of course.) Much of the furniture is second hand, bought because it was cheap and not because it made the convalescent more comfortable. The walls and floors look dull. The recreation and living rooms lack eye appeal, with their dark furniture and rugs. The dining room does not look like a place in which one's appetite might be whetted. The whole effect of the institution is one of confusion; obviously, no thoughtful design and planning have gone into its appearance. Not exactly the atmosphere in which the convalescent may rest and recover!

Here, then, is a field of real endeavor for the far-sighted, alert convalescent home superintendent. He need not fear his own lack of practical experience in "interior decorating," although it is always wise to obtain professional advice. The professional decorator who knows hospitals will be invaluable. Or, some of the large paint companies have made exhaustive and scientific studies of this field as it applies to institutions, and they are ready to assist in planning for more spacious, relaxing and cheerful convalescence.

The superintendent's first step is to determine the use to which each room in the home is put. In planning the color scheme of the rooms he is going to "do," this is his constant guide: "How do we use this room?"

Let us examine first the sleeping units. If patients are grouped dormitory style background is more vital than detail, since fewer accessories can be used for accent. Wall treatment can be either paint or a suitable covering, self-patterned, in harmonizing stripes or simple floral designs. The ceiling need not be a cold white—why should it be, when the patient must spend so much of his time looking at it?—but may be a tint of the wall color or dressed in a contrasting color to the walls. Asphalt tile, linoleum, composition floors all

lend themselves in pattern and color to any decorative scheme.

What about window dressings? If the walls are patterned, venetian blinds are ideal; when plain walls are the rule, window coverings must be carefully selected not only to harmonize with the other colors used but also for ease of cleaning.

Color Improves Appetites

Then, there is the dining room. How can we expect a chronically ill or a convalescent person to want to eat in a room whose colors do unkind things to food? Any color that might act as a depressant should be prohibited in the dining room. Peach is an excellent background for pleasant meal hours. Certain yellows and greens, provided they are clear and free from any bluish cast, are also most appropriate.

If the peach background is used, green would provide a most agreeable contrast when applied on leatherette pads on chairs, on venetian blinds and in a marbleized linoleum floor covering. Patients will find new pleasure in dining in such a room.

Let's take a look next at the recreation room. Here is a spot that should be given most careful thought, since it is the most used and "lived in" room in the home. While it may be impossible to avoid entirely a certain atmosphere of "institutionalism," for a convalescent home cannot be as homelike as a private residence, there is still much that can be done with colors to help make the recreation room pleasant.

Since it is a large room, and we want to make it appear a friendly one in spite of its size, it would probably be wisest to keep the walls as background, arousing interest with curtains, upholstery and accessories. Pine paneling is attractive. Rugs will be used here, even if they are impractical in other rooms, and in this case green rugs would provide good contrast to the paneling. The color scheme used for window dressings, couches and chairs might be terra cotta, natural and green. What a contrast to the drab dismal room we expected to find!

Correct use of color involves more than the color of the walls and floors, of course. What good are soft peach colored walls if the room in which they are used is filled with drab cast-off furniture and accessories, badly in need of painting and fixing? And what good are they if the lighting in the room is so poor that those lovely peach colored walls merely look pale and sickly? So we must also give some thought to the rôle good lighting plays in making a place pleasant to be in. And we must select a color scheme for the room as a whole, employing it throughout as carefully and thoughtfully as we employ certain foods to maintain a balanced diet.

If the home is a large one, with separate sleeping units for convalescents and the chronically ill, there is one rule that, generally, can be safely followed: convalescents will respond best to warmer tones which are stimulating, while the chronically ill will prefer restful cooler tones.

The foregoing outline is necessarily sketchy and incomplete. It is hoped only that the ideas it presents will guide the superintendent toward the goal he seeks. Color therapy is just as important in the convalescent home as it is in the hospital, and for precisely the same reasons. When once the superintendent perceives this truth, realizes that the term "color therapy" is not a misnomer, that colors, as well as vitamins, have a definite bearing upon a convalescent's recovery, that superintendent will already be well along the path of knowing what to do and how to do it.

We still have a great deal to learn about what colors do to those who look at them. But we do know, by scientific test, that they can have either a beneficial or detrimental effect upon the nervous system. And we also know that certain colors please because they suggest certain associations to the human mind.

With intelligent execution the cost of a venture into color therapy need not be prohibitive as the institution may be decorated room by room over an extended period of time. In the long run, the venture may be said to pay for itself; the returns it brings in contented patients and increased business more than justify its initial cost.

Think of the many persons, either aged or chronically ill, who must remain in the home over a long period of time, living with its furniture and walls day after day. Can the humanitarian superintendent do less than give these people a place of comfort and cheer?

Medical Records—Viva Voce

WE FIRST instituted the use of a voice recording unit at Elizabeth Steel Magee Hospital, Pittsburgh, in the spring of 1942. Our equipment includes three recording and three transcribing units. A recorder is used in the operating room suite, where the resident physicians dictate the operative reports; from 12 to 15 operative notes per day are dictated. It is not necessary to have a highly trained medical secretary for this work; a good typist who is thoroughly familiar with medical terminology can be taught to take these recordings off accurately.

The unit saves the time of the physicians and a great advantage is that the doctors can dictate in the evening when they have more free time or immediately after the operation when minute details can be more accurately given. Before we installed the machine it was necessary for the doctors to dictate between 9 a.m. and 5 p.m. The transcriber to this unit is located in the record department.

The social service department has a complete unit. Three case workers dictate an average of 10 or 12 case histories each day which are transcribed by a typist. She need not have shorthand ability.

The third set of equipment is in the x-ray department. The recorder is placed near the film illuminator. The findings are recorded while films are being viewed without regard to the availability of a medical secretary. If the report is needed before sufficient time has elapsed for it to have been transcribed by the typist, the disk can be placed on the transcriber and the report heard by the interested physician.—JESSIE J. TURNBULL, *superintendent, Elizabeth Steel Magee Hospital, Pittsburgh.*

Action Now Toward Better Rural Health

FREDERICK D. MOTT, M.D.*

IF WE will, we can take certain steps in the next few months that will affect rural health profoundly. If we procrastinate, the opportunity will be lost. For the actions needed are directly related to this postwar demobilization and reconversion period.

On the one hand, we have hundreds of rural communities with increasingly serious shortages of physicians, dentists, nurses and other health workers. They lack hospitals, too, and health and diagnostic centers are virtually unknown. On the other hand, many thousands of professional personnel will be leaving the armed forces, an unprecedented reservoir of trained manpower available to meet the nation's needs. And surplus hospital and medical equipment will be at hand in vast amounts, more than sufficient to equip every new rural hospital and health center needed. Orderly reconversion, moreover, will probably call for a program of public works, with health facilities high on the list.

It will not solve the problem simply to construct and equip hospitals and to extend the hand of welcome to returning veterans. Ten to one, the hospitals would be there now if there were effective demand for their services. The basic factor underlying rural deficiencies is economic. Farm people and rural communities lack the kind of medical purchasing power required to maintain hospitals and to attract and hold competent medical personnel.

Reasoned Approach Required

Is the problem insoluble, then? Not at all. But it calls for a reasoned, scientific approach, a willingness to face and deal with facts. It calls for recognition of the essential unity of rural and urban health problems. It demands action at all levels: federal, state and local. It calls for a coordinated attack that will lead to the solution of the numerous problems involved.

Better nutrition, decent housing, wider educational opportunities, improved economic circumstances through full employment, all these are basic to good health. But beyond these are a number of specific measures in the field of health services which demand action just as rapidly as sound plans can be formulated.

It may verge on oversimplification to present these measures as a five point program, but the major objectives listed would bring enormous benefits to rural America if promptly translated into action. The program cannot and should not be approached just from the point of view of rural people but on a nationwide basis.

1. Effective public health services must be organized to cover every rural section.
2. An integrated system of hospitals and health centers must be developed and sanitation facilities must be improved.
3. More physicians, dentists and other health workers must be attracted to rural communities.
4. The scientific quality of rural medicine must be elevated.
5. The basic problem of payment for health services must be solved.

All these objectives, which are really inseparable, are part of the same goal of better rural health.

The organized preventive and educational services of full-time local health departments should be available to every citizen. This will require increased federal aid and, perhaps, mandatory state legislation. We may hope that public health units will be developed on a logical health service area basis, such as that proposed by the American Public Health Association.

Adequate health facilities are fundamental to the provision of medical services of high quality, and we can only attract competent professional personnel to rural districts by making modern hospitals and health and diagnostic centers available for its use. We must develop an integrated system of hospitals and health centers with functional relationships between our leading medical centers and surrounding district and rural hospitals.

It will require federal aid to the states to attain this objective, aid extended on a variable matching basis, in accordance with the relative wealth of each state. The first step in such a program is embodied in the hospital survey and construction bill which has already passed the Senate. I should add that there is, of course, need for tuberculosis and mental disease hospitals and, to complete this brief reference to health facilities, a vast rural sanitation program should be started promptly.

Guarantee Good Income

The third objective, that of attracting well-trained professional personnel to rural communities, can be attacked in a fundamental way through the guarantee of good incomes and through the provision of modern hospital facilities. While these may be accomplished through health insurance and through a grants-in-aid construction program, several steps can be taken without waiting for these programs to exert their full effect.

There might be an agency analogous to the Procurement and Assignment Service, which was responsible for recruiting physicians and other personnel for the armed forces and for relocating physicians to meet civilian needs, to serve a highly useful purpose during demobilization and through this postwar period. Such an agency could furnish information to the men leaving

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Based on talk given at a conference of the Independent Citizens Committee of the Arts, Sciences and Professions, New York City, 1945.

Photograph by Wallace W. Kirkland, Chicago.

Preparing for a delivery in a rural home. Lack of purchasing power causes lack of adequate hospital service in many outlying communities.

the Army and Navy as to the need for their services in specific rural communities, need which cannot be determined solely by local groups.

This agency's functions could be coordinated with hospital planning activities and with the disposal of surplus medical equipment. It might well be given the authority to pay the expenses of moving and of setting up in practice and might even underwrite the provision of a basic income for which a physician might perform certain preventive services in his community. Instead of setting up a new agency to do the job, it would be quite logical to have these interrelated functions performed by the U. S. Public Health Service.

Good Income an Attraction

Even without such organized national action, there are steps which rural communities can take to meet the unparalleled opportunity stemming from the demobilization of tens of thousands of doctors, dentists and nurses. To name a few, a community can offer a doctor a house or office space, purchase surplus equipment for him, pay his moving expenses, guarantee him a basic income, perhaps from county tax funds, or start a prepayment plan to assure him a substantial livelihood. Paying incomes higher than those averaged in cities may well prove to be an effective means whereby rural communities can not only attract but hold personnel of high caliber.

From the long-range standpoint, if we are to increase the supply of rural physicians and dentists, there should be "rural medical fellowships" with preference given to rural youth and perhaps with the obligation to practice in a rural community for a period of time. It would also help to increase the supply of rural professional workers if part of the training of interns and nurses were to be undertaken in good rural hospitals.

Incidentally, through the proper use of nursing services, physicians can save time and serve more efficiently, thus augmenting rural medical manpower. The same is true of professional aides of other kinds: laboratory technicians, physical therapists, optometrists and, in the case of dentists, dental aides, including dental hygienists.

This mention of the use of auxiliary personnel, implying teamwork in medical service, brings up the whole question of elevating the quality of rural medical service. Certainly, group practice clinics, in which a whole professional staff is at the service of the patient, can offer intelligent and economical care. The war has taught us that physicians and related personnel can do a top-notch job on a teamwork basis.

Thousands of veteran doctors are anxious to specialize, and it is perfectly clear that virtually the only way to make the service of any substantial number of them available to rural people is through group practice clinics in trade centers in rural districts.

Fundamental to the elevation of quality, too, is the provision of regular postgraduate refresher courses of various kinds for rural physicians who otherwise naturally tend to "get in a rut." The federal government might help the states establish fellowships or pay generous stipends to make such courses possible.

Even more fundamental in raising the quality of rural service would be the development of patterns of practice around district and rural hospitals which would make possible the continuous flow of knowledge of new developments in medical science from the leading medical centers out to the farthest reaches of the network of medical facilities and to the most isolated rural practitioner. There must be patterns which will foster the continuous education of all practicing physicians, both rural and urban, and which will stimulate active research all along the line.

Must Solve Payment Problem

Our final objective, solving the problem of payment for medical services, is basic to all the rest. If we fail to solve it, rural communities will neither get the physicians and dentists they need nor be able to maintain the hospitals which might otherwise be provided through current legislation. Unless we solve this problem we cannot build a broad program of high quality service emphasizing prevention, thorough diagnosis and complete care.

Experience teaches us that use of the insurance mechanism levels the unpredictable costs of medical care when funds are pooled from a large group of people. Experience teaches us, too, that there are certain inherent weaknesses in applying the insurance principle to health on a voluntary basis. Planning in this field cannot all be done by local communities or by the states. There must be national planning, too.

We have to face the fact that certain states are much poorer than others, usually the rural states. If

rural people in these states are ever to get the benefits of medical science available to those in the wealthier industrialized states, it will only be by a national pooling of funds with contributions from all who can afford to pay, presumably through the use of both contributory insurance and taxation in sound combination.

Only through a program of this kind, as the President has pointed out so forcefully in his recent message to Congress, can a really comprehensive health service be made available to all our people, one which will offer equal opportunity for health to every citizen, urban and rural alike.

Rehabilitation Is a Good Investment

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SINCE the passage of the Vocational Act of 1920 there has been a program for the rehabilitation of physically handicapped persons, conducted by the rehabilitation divisions of the various state boards of vocational education, with assistance from the federal government in the form of grants-in-aid. Up to 1944, under this program, 255,000 disabled persons were restored to useful, remunerative employment and to self-respecting, self-supporting lives.

For every person permanently disabled, some form of support must be provided. In the past, this has too often meant community charity—a temporary remedy at best—at an average per case cost of $300 to $500 a year. Vocational rehabilitation is effected at an average per case cost of $300, which is a nonrecurring expenditure. The results of these services, measured statistically over a one year period, disclose the returns that accrue from the investment.

44,000 Found Employment

During the fiscal year 1944, almost 44,000 disabled persons were rehabilitated into employment. The total earnings of these 44,000 disabled individuals increased from about $6,500,000 a year, prior to rehabilitation, to about $78,000,000 after rehabilitation, an increased earning capacity of $71,000,000 at a rehabilitation cost of approximately $13,000,000.

There are no financial yardsticks to measure the difference between a self-reliant citizen carrying his own responsibilities and a depressed citizen dependent upon charity. Those differences, moreover, mean more than dollars and cents in terms of happiness, good citizenship and social usefulness. Complete use of our manpower is, and will remain, in peace or war, a human problem of serious import to the welfare of the nation.

What had been accomplished up to 1943 was clearly far short of the need as indicated by the total number of handicapped persons, because the original law had a number of limitations that made a complete program impossible. There was a statutory limit on the federal grant; no physical restoration services (medical treatment) were included; no special services for the blind were provided; federal funds could not be used to provide maintenance during rehabilitation, and mentally and emotionally handicapped persons were not eligible for service.

In short, the services were limited, for the most part, to vocational counseling, vocational training, prosthetic appliances and placement services for the physically handicapped.

Discrimination against the mentally ill has long been a flagrant feature of society's plans for medical care and rehabilitation. In spite of the fact that more than half of all hospital beds are occupied by mental cases and about half of all cases of disability are mental in character, the standard of care in some mental disease hospitals is more commensurate with that of second-rate jails than of modern hospitals.

The inadequacy of care is also reflected in the fact that most hospital and medical care insurance plans arbitrarily exclude service for those persons who are mentally ill.

Recognizing the limitations of existing legislation and the unmet needs of the disabled, as well as their potentiality as a reservoir of untapped manpower, the Congress in July 1943 enacted a series of amendments to the Vocational Rehabilitation Act in Public Law 113, known as the Barden-LaFollette Act.

The program of vocational rehabilitation now includes the mentally, as well as the physically, disabled. Thus, psychiatric care and other rehabilitation services can be provided for persons with mental disabilities, for persons with physical disabilities complicated by psychiatric difficulties and for persons with mental retardation.

Effect Will Be Far-Reaching

The significance of this federal legislation which recognizes psychiatric rehabilitation as practical and economical is likely to be far-reaching. As the rehabilitation program is developed and demonstrates that hopefulness instead of despair should mark at least some cases of mental illness, the prejudice and stigma which have been associated with mental illness may begin to disappear.

The physical restoration features of the new rehabilitation program do not comprise a general medical care program; everything that is done for and with a rehabilitation client is related to his employability and a specific employment objective. In the first place, the individual must have a disability that is a substantial employment handicap. Second, for physical restoration services, the disability must be "static" or slowly progressive. Emergency care or treatment for acute illness or injury may not be given.

A third limitation, with regard to physical restoration, is that the dis-

ability must have a favorable prognosis in that it may be expected to be removed or substantially reduced with a reasonable amount of treatment. If hospitalization is required, federal financial participation in the costs of such treatment is limited to ninety days. This limitation was obviously intended by Congress to bar from this program the long-term care of chronic conditions that cannot be improved to any appreciable degree.

Finally, there is a fourth limitation on medical services of a somewhat different character, namely, that physical restoration services may be provided at public expense only insofar as the individual is unable to pay for the services. The basic medical examination, including consultation by specialists, if necessary, and the fundamental services of vocational guidance and counseling, vocational training and placement may be furnished without cost to the client, regardless of his financial resources.

Can Pay in the Future

It is an objective of the program to assist persons who are unable to pay the cost of the necessary medical and hospital care and thus enable them through rehabilitation to pay in the future. Within these limitations much gratifying restoration of both physical and mental disease cases can be done under the guidance of the professional advisory committee and the technical rehabilitation staff being assembled in each state.

Under the expanded authority of the amended rehabilitation act many states are already exploring the opportunities for rehabilitation of psychiatric cases. To mention a few, Vermont, Connecticut, Maryland and the District of Columbia are purchasing psychiatric treatment for many cases. Michigan and Texas are doing notable work in taking mentally retarded persons from state institutions and placing them successfully, with guidance and supervision, in the community.

California is assisting in the community adjustment of parolees from state mental disease hospitals and is also giving special attention to the rehabilitation of merchant seamen. The marine hospitals of the U. S. Public Health Service and the rehabilitation agencies of other states, New York, for example, work as effective teams to give as complete rehabilitation services to merchant seamen as the Veterans Administration furnishes to eligible veterans. Illinois provides both out-patient and in-patient psychiatric treatment for some former servicemen who are not eligible for rehabilitation from the Veterans Administration.

Because the hospital has as its major function the medical rehabilitation of the sick and injured, it has much in common with the rehabilitation agency. The combined efforts of the two are frequently needed to complete the successful rehabilitation of a disabled person regardless of whether he first seeks assistance from one agency or the other. With extended functions and increased financial resources, the state rehabilitation agencies will be of more value than ever to hospitals. Most state rehabilitation agencies have district offices so there is opportunity for close working relationships with hospitals wherever they are.

Any civilian of employable age who has a health defect that constitutes an employment handicap is eligible for rehabilitation service and all hospitals, whether general or special, private, voluntary or public, may refer cases freely. Experience in Army and Navy hospitals has shown that, in order to speed convalescence, the need for rehabilitation service should be anticipated as early as possible so that counseling can begin while the client is still in the hospital.

Besides referring cases for rehabilitation services, there is another way in which hospitals can be served—by accepting handicapped workers for training and employment. Hospitals have always used more than their share of such people and realize that, if properly placed and trained, they make excellent workers. With the specialized assistance of the rehabilitation agent still more such persons can be employed to mutual advantage.

For example, it has been truthfully said that there are more jobs for the feeble-minded in this world than there are feeble-minded persons to fill them but some employers have tried to avoid them. Several years ago it was shown that some parolees from state mental disease hospitals make satisfactory employes for general hospitals.[1]

The usefulness to rehabilitation agencies of the better mental disease hospitals that give intensive treatment goes without saying. Unfortunately, many so-called general hospitals continue to discriminate against emotional and mental disease cases, although such cases may not be dangerous or psychotic and might be handled with a reasonable amount of special facilities.

It is unfortunate that the person with a temporary reactive depression or the returned serviceman with an anxiety psychoneurotic state should be denied care in the hopeful cheerful surroundings of the modern general hospital, where he would have a much better chance for recovery than if he is denied hospitalization or is forced into a custodial type of mental disease hospital.

Service Should Be Continued

It is to be hoped that general hospitals will continue the present trend toward better and more convenient psychiatric consultation for all in-patient and out-patient services. The importance of emotional factors in all kinds of "physical" disorders is tremendous. No general or nonpsychiatric hospital can exclude these psychosomatic cases and none can afford to ignore them. At least one general public hospital believes that an active psychiatric consultation service pays for itself by shortening the average hospitalization period.[2]

The hospitals that make the best provision for the emotional complications of illness will be the most helpful to their patients and, therefore, the most useful to rehabilitation agencies.

The war has done a great deal to expose the false distinction which has traditionally been made between "mental" and "physical" illnesses. We know now that a sick man is a sick man, that he is likely to have both physical and mental symptoms; and the time is coming when he can go to his doctor, his hospital, his medical care plan and his rehabilitation agency without discrimination if his presenting symptom happens to be mental or emotional in nature.

[1]Bellsmith, Ethel B.: Some Industrial Placements of Women Patients Paroled From a State Hospital, Mental Hygiene **23** (January) 1940.

[2]Billings, Edward G., McNary, William S., Rees, Maurice H.: Financial Importance of General Hospital Administrators, Hospitals **11**:40 (March) 1937.

About People

Administrators

James Russell Clark, head of the Washington Service Bureau of the American Hospital Association, has resigned that post to become superintendent of Brooklyn Hospital, Brooklyn, N. Y., where he will succeed **Dr. Willis G. Nealley.** Prior to joining the American Hospital Association, Mr. Clark was superintendent of the Southside Hospital, Bay Shore, N. Y. **Albert V. Whitehall** has been named to serve as acting director of the Washington bureau.

Alice E. Snyder, R.N., superintendent of St. Luke's Hospital, Marquette, Mich., has assumed her new duties as superintendent of Geneva General Hospital, Geneva, N. Y. She succeeds **Florence Bloomer** who resigned.

John C. Van Metre of Iowa has been appointed director of Portsmouth Hospital, Portsmouth, N. H., succeeding **Richard O. West,** now in a similar post at Salem Hospital, Salem, Mass. Mr. Van Metre, a graduate of the course in hospital administration at the University of Chicago in 1941, spent the last four years in an evacuation hospital in North Africa and Italy. He held the rank of captain at the time of his discharge in February. Prior to entering the service, Mr. Van Metre was administrative assistant in the Hospital of the Protestant Episcopal Church, Philadelphia.

H. G. Fritz, administrator of Conemaugh Valley Hospital, Johnstown, Pa., has resigned to accept the appointment of the hospital survey committee as executive officer for the survey in Maryland. His successor at Johnstown is **Max E. Gerfen** who has recently been at the James W. Sheldon Memorial Hospital, Albion, Mich.

Dr. Pascal F. Lucchesi, superintendent of Philadelphia Hospital for Contagious Diseases, Philadelphia, has been appointed superintendent and medical director of Philadelphia General Hospital. He succeeds **Dr. Ignatius S. Hneleski** who resigned to enter private practice.

Burton H. Morrell has resigned as superintendent of Princeton Hospital, Princeton, N. J.

Kenneth H. Gordon has assumed the duties of assistant director of Woman's Hospital, New York City. He succeeds **Emily W. Bauer,** who retired after fifteen years' service as assistant superintendent. Mr. Gordon recently completed his terminal leave after serving with the United States Naval Reserve for thirty months. Prior to military service, he had been superintendent of Greene County Memorial Hospital, Waynesburg, Pa.

Evelyn Johnson is the new superintendent of Brokaw Hospital, Normal, Ill. She formerly was acting executive secretary of the Chicago Hospital Council.

Elmina L. Snow, who recently resigned as superintendent of Cortland County Hospital, Cortland, N. Y., has been appointed superintendent of Emerson Hospital, Concord, Mass.

Brig. Gen. George C. Beach, commanding general of Brooke Hospital Center, Fort Sam Houston, Tex., since 1942, has assumed command of the Army Medical Center at Washington, D.C., according to an announcement of the Surgeon General's office. He succeeds **Maj. Gen. Shelley U. Marietta,** who is retiring from active service.

Jerome L. Benzing, superintendent of J. Lewis Crozier Home for Incurables and Homeopathic Hospital, Chester, Pa., since 1942, retired April 1. Prior to directing Crozier Hospital, Mr. Benzing had served the Bell Telephone Company for twenty-eight years, the last years as district manager at Chester; he retired from that post in 1932. The years following were devoted to civic works and, in 1942, he was asked to accept the post at Crozier Hospital.

Yellena Seevers has resigned as superintendent of Bath Memorial Hospital, Bath, Maine. Prior to her post at Bath, Miss Seevers was senior industrial specialist, Hospital Section, W.P.B.

Grace Cordon, former superintendent of Columbus County Hospital, Whiteville, N. C., has been appointed superintendent of Woman's Hospital, Pasadena, Calif., succeeding **Mrs. Ruth Hayes** who has retired after serving there for three years.

Sister M. Liguori has returned to St. Luke Hospital, Pasadena, Calif., as superintendent after an absence of five years. She succeeded **Mother M. Francis** who is now a superior of one of the houses conducted by the Sisters of St. Joseph at Sidney, Australia.

Mary G. McPherson, administrator, Ellis Hospital, Schenectady, N. Y., has retired from this post which she has occupied for the last twenty-one years.

Maj. Ronald D. Yaw has been awarded the Army Commendation Ribbon for services performed at Schick General Hospital, Clinton, Iowa, where he is executive officer. Established in December 1945, the Army Commendation Ribbon is the newest Army decoration and is the nonoperational equivalent of the Bronze Star Medal; the required standard of service for each award is the same. Major Yaw is on military leave of absence from his duties as director of Blodgett Memorial Hospital, Grand Rapids, Mich.

Mrs. Gertrude R. Folendorf of San Francisco, administrator of the sixteen Shriners' Hospitals for Crippled Children, has been appointed to the board of regents of the American College of Hospital Administrators, and will have jurisdiction over ten western states. Mrs. Folendorf's appointment fills the vacancy created by the recent death of **Dr. Benjamin Black.**

Department Heads

Edith M. F. Pritchard has been appointed director of nursing at Beverly Hospital, Beverly, Mass.

Ralph J. Hendrickson, C.P.A., has been appointed to the newly created post of comptroller of Presbyterian Hospital, Chicago. He is a graduate of the University of Texas and has had considerable experience in the auditing of hospital books.

Arthur W. Harvey, formerly purchasing agent at Western Pennsylvania Hospital, Pittsburgh, has returned to his post after being discharged from the Army as major in the Medical Administrative Corps. He was medical supply officer with the 58th General U. S. Army Hospital which was organized and affiliated with Western Pennsylvania.

Winifred Halvorsen of Carpio, N. D., has been appointed assistant dietitian at Huntington Memorial Hospital, Pasadena, Calif. She is a graduate of Iowa

(*Continued on Page* 172)

The Pattern for Complete Service

includes preventive medicine and home medical service

J. J. GOLUB, M.D.
Director
Hospital for Joint Diseases, New York City

IN MANY parts of the country, state and city planning commissions are engaged in detailed studies of their respective communities. On the basis of such studies planning begins and concerns itself with physical and locational aspects of streets and highways, wharfs and waterways, transportation facilities, industrial and commercial areas, parks and playgrounds, fire protection stations, police stations, schools, hospitals, dispensaries, health centers, welfare agencies, housing, public and private buildings, sewerage and sewage plants, water supply and other public utilities. It extends into quantitative and qualitative aspects with the object of providing sufficient and proficient service to all of the people. The aim is to develop and implement an over-all plan of future life.

It Will Be a Different World

Planning envisages that future life will be lived in a social and economic world different in several essential aspects from the present one. It assumes that the ways of life of the remaining years of the twentieth century cannot satisfactorily fit into a nineteenth century framework and pattern such as prevails over a large part of the country. It recognizes that the rapid growth of our country and cities, stimulated by free enterprise, created dense and large concentrations of populations; that urban and suburban areas were haphazardly occupied; that city sections changed from residential to business or industrial areas, and that populations shifted so that hospitals and schools and other welfare, health and recreational services are in many instances no longer near the people they were intended to serve.

Commerce, industry, transportation, education, housing, recreation, health and social welfare cannot progress and adequately serve all the people when they are hampered by physical, locational, organizational, quantitative and qualitative limitations. Hence, areas of whatever geographical or political boundaries must be replanned, and they must be replanned by the people of each locality to suit special needs. It is not possible to draw a standard blueprint in Washington for application to Pittsburgh.

Advice of experts in planning may be sought but they can give it best when they study and know the community that is to be replanned. A satisfactory plan could only become so if, in addition to experts in special fields, educators, sociologists, economists, industrialists, representatives of labor and management, architects and engineers, physicians, nurses and public health workers, church and government leaders and representatives of welfare and health agencies selected from the local community participate in fact finding and the formulation of plans.

Sound city planning, also, considers its effect on neighboring small communities and the people residing in near-by rural areas who so often depend on the city for certain services.

Tomorrow's city will be not merely the result of slum clearance and construction of roads and buildings. It will involve health planning, cultural planning, social planning, planning for earning a livelihood and service to the people by governmental and voluntary effort. Of these, not the least important is opportunity for well people to remain well and to work and earn.

A good plan of itself will do much toward achieving these things locally; but beyond that, extensive city planning throughout the country will help substantially to solve the troublesome problems of unemployment which so many are expecting unless intelligent and advance preparations are made. The substantial amount of work involved in replanning a city from its first stage through the stages of construction and reorganization will require large numbers of workers of all skills, and even the unskilled.

One of the basic principles of any plan is that it must be sufficiently flexible to permit adapting any of its services in keeping with corresponding trends in the needs of the people. A proper plan must prevision future needs for a reasonable number of years and must at all times adjust itself to meet changing conditions and demands.

Health Is Integral Feature

A comprehensive health program for all of the people is an important aspect of any plan but never is independent of all other services. It includes: environmental sanitation; water, food and milk supply; sewerage, waste and garbage disposal; sanitary construction of homes, offices, factories, schools and institutions; hospitals of all types, dispensaries, health centers, pharmacies, dental clinics, day nurseries and other institutions and welfare agencies.

In the location, orientation and planning of buildings, a health program embraces provision for sunlight, ventilation, quiet surroundings, elimination of obnoxious odors and consideration of convenience of residence to work places and service centers. In a word, the program takes into account living and working conditions of the people who are well, accessible medical services at high standards for the people who are ill at home and in the hospital and, above all, facilities and measures directed toward prevention of disease.

The primary aim is no longer to beautify a city or to make it rich or big but to make it a livable city, one in which people can be happy.

This description of the objectives of city planning serves as a setting for the discussion of the proposed enlargement of hospital aims with the object of making hospital service more nearly complete, properly fitting it into the over-all service programs that will emanate from the efforts that are made to replan our communities.

It is generally agreed that an intelligently conceived program for any institution must conform to preconceived aims; however, it must also be sufficiently flexible to enable it to alter its ways from time to time to meet changing conditions. Can that be said of hospitals?

Uniformity of Objectives

There is considerable uniformity in the aims of American hospitals. We are accustomed to the definition of a hospital as being a place in which patients receive medical care and the benefits of medical social service, physicians can learn and teach medicine, medical students and student nurses can be taught and clinical and laboratory research work can be pursued.

While these aims are commendable and must at all times be continued, it must be recognized that the services they render to the sick are incomplete. Hospital authorities and physicians, if they desire their institutions to render complete and effective service to meet changing conditions and community needs, must concern themselves with two additional aims, which logically belong to the hospital. They are: (1) preventive medicine and (2) home medical care.

Preventive Medicine. The hospital's position with respect to preventive medicine has never been clearly defined in terms of either program or performance despite the fact that the hospital is the natural source of both. Out of the hospital should radiate important scientific advances that aim at prevention of disease and at methods of instructing people in the practices of hygiene at home, at school, at work and at play.

Medical science, because of its dynamic quality, has always found the hospital a suitable proving ground for its investigational work, its rapid change of methods, and even opinion, and its progress. Its contribution has been to both so-called curative medicine and preventive medicine, and the two should be utilized by the hospital in its service. A community, too, is a dynamic organism. Its needs change because its composition and external influences change. Since community life cannot stand still, community institutions cannot do so either.

Government Is Reaching Out

The related preventive medicine aspect of the government's public health program is largely concerned with controlling communicable diseases and enforcing sanitary measures, although in recent years municipal governments, in their disease prevention programs, have gone somewhat beyond these two major activities and reached out directly to the people by building and maintaining health centers, a work that could be done well by out-patient departments of municipal and voluntary hospitals. But neither governmental nor voluntary hospitals, for the most part, have integrated their programs with preventive medicine. They have not given it the attention it deserves and needs.

Diagnosis and treatment of disease are not enough. Such activities as health education, prenatal care, child health, dental hygiene, mental hygiene, nutrition, prevention and control of tuberculosis and venereal diseases, immunization and vaccination against other diseases should normally be a part of the hospital's program. Then, too, the hospital should be the regional quarters for health associations, district, visiting and school physicians and nurses and all who serve a given population in the interest of disease prevention.

The hospital that includes among its aims the feature of disease prevention will be aiding in: the processes of diagnosis and cure of patients; the education of staff physicians and medical students who would become more proficient practitioners, more alert to and conscious of the importance of preventive medicine and thus of greater service to the people, and the training of nurses and medical social workers who are vital aids in any medical program. Above all, it will bring about a reduction of preventable acute and chronic illness among the people it serves.

Home Medical Care. The hospital as it functions today in relation to community needs is incomplete in its service in another aspect. In admitting and treating the average ambulatory or bed patient, it begins its diagnostic and therapeutic service somewhere in the middle of the disease or disability. It can begin at the beginning and end at the end of disease by adding home medical care as one of its activities.

Save for patients suddenly stricken on the street or at work, people first become ill at home. At that point a physician should be available. Early diagnosis means early therapeutic measures. Early recognition of communicable disease and its isolation safeguard the health of family and neighbors. Early and proper treatment lightens the severity and shortens the length of illness. These have an important bearing on costs of medical care and on loss of earnings.

The patient's illness dossier begins at home. If he is admitted to the hospital, it is continued at the hospital and when he is discharged, it is further continued in the out-patient service or at home. Should he, after recovery, become sick again, all previous records are available, are known to the hospital and its staff and can be an important guide in future diagnosis and treatment.

It is a paradoxical practice, which is insupportable by any explanation, that the poor can receive free or part-pay care in hospitals and dispensaries, but when they are ill at home they in many instances remain unattended.

Would Reduce Bed Occupancy

As poor and low-income people of established inability to pay private physicians for their medical care learn that their local hospital also provides home medical care rendered by physicians and nurses paid by the hospital on the basis of fixed fees per visit or by salaries, they will utilize the service, receive early care and thus often avoid prolonged illness. Incidentally, adequate home medical care would reduce hospital bed occupancy, thereby vacating beds for patients requiring and awaiting admission to hospitals.

These two additional aims—preventive medicine and home medical care—would make the hospital a truly physical and functional facility, set up for a coordinated and complete health service to local population groups.

We Need Blue Cross

HOWARD CUYLER RIES

Trustee, General Hospital, Everett, Wash.
and Washington Blue Cross

THE hospital trustee who faithfully supported his local hospital through the years of scant income before the war and struggled manfully to arouse the interest of his community in his institution must certainly shake his head and feel a bit dazed at the sudden burst of publicity in the newspapers about hospitals and at the cascade of bills in Congress appropriating millions for hospital expansion throughout the nation. Times have changed—and how.

The vast expansion of hospital facilities and the proposed establishment of a national compulsory health insurance program are the easy, indirect approach to the problem of the cost of hospitalization. The trustees of voluntary community general hospitals, however, have no choice but to struggle with the current daily problems of hospital administration. One of the most perplexing problems has been the collection of overdue accounts from families of moderate means, to whom a substantial hospital bill becomes a financial disaster.

Led to Rise of Blue Cross

The determination to solve this problem resulted in the establishment of various types of prepaid hospital service plans in a number of scattered communities and, in due course, led to the development of the Blue Cross movement. The year 1946 opens with approximately 20,000,000 persons covered by Blue Cross plans. The great expansion of this service from an enrollment of four or five million in 1936 to 20,000,000 at the present time is evidence in itself of the great public need for which the Blue Cross supplied the answer. Indirectly, it is a magnificent testimonial to the great esteem and public confidence enjoyed by the voluntary community general hospitals of America.

As an insurance salesman with extensive experience in the writing of accident and health insurance and the operation of group disability programs, I have observed the refusal of insurance companies, until quite recently, to extend hospitalization or any other kind of health coverage to the dependent families of employed persons. Such accident contracts as were issued have been drastically limited. Industrial medical aid contracts usually avoided groups containing a substantial percentage of women employes or they charged them a heavy extra premium.

Since dependent members of families constitute approximately three fifths of hospital patronage, the need for some type of group distribution of hospital expense for the benefit of family dependents has long been recognized by hospital administrators.

The Blue Cross system of prepaid hospital service was, therefore, developed to provide the answer to a problem which was a burden on the finances of the hospital as well as on the family. It need hardly be stated that this problem gave no concern whatever to insurance companies in the past, as it is evident today that many persons in the insurance business take an extremely narrow view of the situation and can see the advancement of the Blue Cross only as the rise of a competitor in the field of insurance. They do not recognize the fact that at least half of the persons now covered by Blue Cross service would have been repudiated had they applied to the insurance companies for hospital bill coverage. This narrow point of view is held also by other groups that are critical of the Blue Cross program. None of them showed any concern whatever in the past for the financial problems faced by the hospitals, nor do they show any at the present time. Few of them show much concern over the cost of hospital service to families. In truth, the Blue Cross movement has been an adventure into an unexplored field of public service.

Blue Cross coverage will, in due course, include every illness that may be admitted to a general hospital. There are some limitations in various plans at this time which have been imposed to correct some abuse or to reduce heavy loss experience; but, on the whole, Blue Cross service has entered into fields that have been strictly avoided by agencies engaged in the casualty insurance business.

Charge Must Offset Cost

It is this effort to cover every person who needs to be a patient in a hospital rather than to choose only favorable risks which takes the Blue Cross movement out of the field of insurance and points up its true character as a readjustment in the economics of the distribution of hospital service. In other words, it is simply a new basis on which hospitalization will be merchandised in the future to the entire population, without regard to health history or chronic ailments or present occupation. It is inevitable, therefore, that the monthly charge to the family must offset the cost of service to hospitals.

Hospital trustees should carefully consider the theory that hospitals should accept less than the cost of doing business as compensation for Blue Cross cases, as a few people have suggested. The argument runs that this is a social program and that the hospitals should be willing to accept payments for Blue Cross patients which do not include a charge for the maintenance and upkeep of the hospital plant. This is one claim.

It is further argued that the community provided the funds for the hospital in the first place and that the members of the community who used Blue Cross service should not be compelled to pay the cost of the upkeep and rehabilitation of these properties. It is doubtful that these statements will carry much weight in the minds of trustees who are charged with the responsibility of a community general hospital.

In the first place, those who provided the funds for the construction of a community hospital are at most a mere handful of the persons who will use the Blue Cross service. This formula forces those responsible for the maintenance of the hospital to go to the same group that built it and beg additional funds to maintain it.

It seems wholly reasonable that any family can, without hardship, pay $3 a month for hospitalization coverage. If it cannot do so, the members of such families should be treated as charity patients. For the ultimate good of the public and the maintenance of community hospital facilities on a basis adequate to the needs of each community, the service given to any but charity patients should stand on its own feet financially.

Less Than Adequate Rates Paid

Hospitals must protect themselves from domination by outside forces that are interested only in the purchase of hospital care at low cost, regardless of the effect on our standards of service to patients. There is a strong tendency on the part of group hospitalization programs, whether under government or private auspices, to provide service to the patient on the basis of ward bed accommodations and to pay less than adequate rates.

Approximately one fourth of our national population will be eligible for hospital care under provisions of veterans' benefit laws. The Veterans Administration, which faces a considerably higher cost in veterans' hospitals, may also be asking local community hospitals to sign contracts to supply service at rates less than cost.

Legislation in Congress will attempt to make the E.M.I.C. program a permanent peace-time program, under which the general hospital would waive its right to manage the patients who come under this program. Hospitalization provisions on accident and health policies in the nation have shown an increase of approximately 685 per cent in premium income to underwriters over a period of five years.

In addition to these groups, which do not include a number of government agencies that developed hospitalization service as a part of their program, we must take into account the numerous group health organizations in various parts of the country, and also our own Blue Cross program. It would seem to be imperative, therefore, that the hospital industry of the nation must set a safe standard of charges for patients coming in under group coverage.

The Blue Cross agencies, under hospital control and direction, should have the experience and authority to speak for hospitals in establishing rates and administrative procedures in relation to the hospitalization of large groups of people. In my judgment, the Blue Cross rate of compensation should be a yardstick to force adequate rates from other group hospitalization programs and it should be the business of the trustees of every hospital to see that patients come reasonably near paying their way, whether they come to the hospital under a government program, a private contract with a railroad or an industry, an insurance company, a medical aid bureau or our own Blue Cross.

I believe that the independence of our hospitals and the retention of the control of our community institutions in the hands of the local boards of directors are fundamentally necessary to the preservation of our conception of adequate hospital service. I also believe that the Blue Cross system of prepayment is the answer to the demand for a reduced cost of hospital service to the patient.

In promoting the development of this Blue Cross program the hospitals are operating in their own legitimate field and are entitled to work out their destinies without criticism or interference from any other profession or business. The public has indicated that it does not object to this development in hospital service. Each state hospital association should exercise a controlling influence in the affairs of the Blue Cross plans within its area. The proper status of the Blue Cross plan is that of an agency of the state hospital association and not an insurance company.

We hospital trustees take the responsibility for these institutions because we want adequate and proper care for the patient. Our hospitals were built primarily to care for sick patients and, generally speaking, we are interested only in maintaining them for that purpose. We object to domination by any outside agency because we believe that remote control of any character will destroy good service to the patient.

Question of the Month

QUESTION: We feel the need of reorganizing our board of trustees but hesitate to do so because of the fear of creating bad feeling on the part of certain individuals. Do you know of any hospital that has accomplished this recently and what the reaction has been?—L.M.P.

ANSWER: Yes, one institution in particular has just effected such changes and the report of its president follows: "The reorganization of the ..... board of trustees has been most beneficial. Prior to reorganization, there were some 36 members of the board. The group was too large and it was almost impossible to obtain frank opinions and discussion at board meetings. There was always someone whose feelings would be hurt. Furthermore, some board members had long outlived their usefulness and, while they regularly attended the meetings, they did not do the active committee work required. To correct the situation, the by-laws were completely rewritten, limiting the board membership to 24.

"The board is divided into thirds and a trustee is elected for a three year term. Each year, therefore, the terms of one third of the board membership expire. Provision was also incorporated in the by-laws whereby board members cannot serve for more than two consecutive terms. After being off the board a year they can be reelected again. This provision ensures a turnover and a continuous supply of new blood, which brings with it new enthusiasm and ideas. With a smaller group, the meetings are less formal and the discussion is intimate and frank. Working committees function better, as everybody must do his share to get the necessary work done. There can be no drones.

"I fail to see that the interest of old board members who were dropped in the new organization has waned and, certainly, the hospital business is better conducted than it was with the large unwieldy group."

Coming Trends in Medical Care

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SCIENTIFIC discoveries affecting diagnostic methods and the treatment of disease are constantly changing the nature of medical practice. Just as today's methods are sharply different from those of a generation ago, so will tomorrow's be different from today's. Some trends that will influence medical care in the future are already discernible.

There will be fewer patients with acute communicable diseases and more with degenerative diseases; more preventive medicine and health counseling; more psychiatry, including child guidance and psychiatric study of medical patients; more cooperation between physicians and social workers, dietitians, occupational therapists and others in related fields. Developments in transportation and the economics of medical care will also play a part in the emergence of new types of practice, as will increasing public awareness of medical facts and understanding of health problems.

Important Progress Made

Scientific progress in the communicable diseases already has done much to change the character of medical practice. In the latter decades of the nineteenth century and in the twentieth century important discoveries have been made in the early diagnosis of diphtheria, whooping cough, scarlet fever, typhoid fever, meningitis and other communicable diseases. Progress in the detection, prevention and care of tuberculosis is known to all.

In 1900, seven of the 12 principal causes of death were communicable diseases. In 1943, only four of the first 12 were communicable diseases. The physician of 1950 will see relatively few patients with typhoid fever, diphtheria, whooping cough and meningitis. Improved public health measures and effective preventive measures have reduced the incidence of many of these diseases to all-time lows.

Not only the numbers of patients who contract these diseases but the seriousness of the illnesses have been reduced. Treatment with convalescent serums, antitoxins, the sulfonamides and penicillin has shortened the period of illness and reduced mortality rates. Scarlet fever, measles and meningitis have all had their normal course remarkably shortened.

Pneumonia is a good example of the change in prognosis brought about by the use of sulfonamides and penicillin. Mortality rates per hundred thousand population for pneumonia varied between 160 and 200 from 1900 to 1920. In 1943, the rate was 67 per hundred thousand.

In addition, and especially important to hospitals, the course of pneumonia has been sharply reduced. In 1900, as in 1930, the average duration of the acute illness was a week. A two week period of convalescence was followed by several weeks of gradually increasing physical activity. The physician of 1900 saw his pneumonia patient for at least a month. Sulfonamides and penicillin have reduced the acute illness to a matter of from thirty-six to sixty hours. The convalescent period and resumption of normal activity are correspondingly reduced, as the patient has not been subjected to an extended illness.

Venereal diseases have long been a concern of physicians. Local treatment of acute gonorrhea and prolonged treatment of syphilis constituted a fair share of the office practice of the doctor of 1900. Continuous penicillin treatment of acute gonococcus infections and the rapid treatments for syphilis are the modern methods, and they require hospital care. Reports from special centers for the treatment of venereal diseases indicate that early diagnosis and effective treatment can best be given in properly staffed and equipped institutions.

The surgeon of 1900 frequently did resections of tuberculous glands, curettements of osteomyelitis, mastoidectomies and thryroidectomies. Today, tuberculous cervical adenitis is virtually a disease of the past. Closed plaster-of-paris methods, sulfonamides and penicillin have combined to reduce the incidence of osteomyelitis; the most compound fractures can be successfully treated without the occurrence of osteomyelitis. It is likely that the lessons learned during the war will do much to reduce further the occurrence of bone infections in civilian practice.

Fewer Mastoid Cases Recorded

Not infrequently in the past acute otitis media spread to the mastoid cells, necessitating a mastoidectomy. Again, the sulfonamides, penicillin and now streptomycin are responsible for controlling most of the acute infections of the middle ear. In one hospital in the Chicago area, in which there were usually about 36 simple mastoidectomies performed yearly from 1930 to 1935, only eight a year have been performed since 1940.

The treatment of tuberculosis has undergone several shifts in point of view. Complete bed rest, forced feeding and plenty of fresh air were formerly the cardinal features of therapy. Many patients were treated at home. Later, there was a concerted move to have nearly all tuberculous patients sent to sanatoriums, so the disease became largely one of hospital practice. Miniature x-rays of the chests of inductees, school children and prospective employes have revealed many early cases of tuberculosis.

Today modern methods of treatment help in the early arrest of the disease, give moderately advanced or chronic cases a more favorable aspect and reduce the course of the disease

Condensed from an address given at a branch meeting of the Chicago Medical Society.

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tremendously. Many patients can be successfully managed in clinics after a short period of hospitalization; care of the tuberculous patient has become a combined hospital and office problem for the physician today.

The age composition of our population has changed greatly over the years. More people live longer now. Thus, physicians in coming years will be required to treat more patients with degenerative diseases. The constantly increasing number of deaths from heart diseases, diseases of the coronary arteries, intracranial vascular diseases and nephritis point to the greater need for medical care in this field in the future.

Cancer and other malignant tumors will require more attention from the profession. The management of patients with tuberculosis and syphilis has been mentioned, and it is likely that they will be handled by specially equipped and staffed clinics and hospitals. Diabetes mellitus will be an increasingly important disease in the future. Joslin has estimated that there are between 450,000 and 500,000 diabetics in the United States.

Better understanding of nutrition has given physicians an appreciation of many metabolic processes. It is believed that doctors, in conjunction with dietitians, will give more advice about nutritional problems in the future than was done in the past.

Developments in Psychiatry

Developments in psychiatric fields have been especially noteworthy in recent years. In the past attention was given primarily to those with frank psychosis and treatment consisted largely of nursing care and sedation. An idea of the magnitude of the problem may be gathered from the statistics accumulated by the U. S. Bureau of the Census:

There were 20.5 patients per hundred thousand population in mental disease hospitals in the United States in 1910; 25.3 in 1922; 32.3 in 1933, and 37.9 in 1943. Some have estimated that there are about 2,000,000 psychotic patients in the United States. Improved facilities for the early detection of mental disease and a better insight into dynamic mental processes are responsible for uncovering much mental illness that formerly escaped detection.

Many people who formerly got along fairly well in rural communities and were accepted as "a little queer" find it difficult to adapt themselves to modern city life. Improvements in transportation and communication have done much to urbanize rural communities, thus leaving fewer regions in which the mildly psychotic patient can live reasonably unmolested.

Psychoanalysis, narcosynthesis, shock therapy and other modern methods have done much to help the psychotic patient. Doctors have become aware of the wide applications of psychiatry to medicine, and some are keenly interested in psychosomatic medicine. Patients with mild psychosis have too frequently been disparagingly called "darned neurotics" and have been unintelligently treated or, frequently, neglected.

Psychotic Illness Is Real

We are just emerging from the purely mechanistic period in medicine, wherein a microbe, fracture or murmur had to be found or the patient was not sick. The doctor of 1946 is aware that the patient with a psychotic illness—maladjusted to his job, his marital situation or other aspects of his life—is as genuinely ill as a patient with lobar pneumonia. The doctor of the future will spend much of his time in the detection and correction of mental illnesses. Even in 1943 suicides were the eleventh most important cause of death in the United States, and it is generally recognized that they follow a failure to help the individual solve his problems.

Less dramatic but surely just as effective will be the extension of child guidance clinics and behavior advice. The physician of the future must be prepared to work with the psychiatrist, the psychiatric social worker and the clinical psychologist, as well as the occupational therapist, in order to give the patient the full benefits of modern medical treatment.

The provision of adequate medical care for everyone is an important responsibility of the medical profession. A decrease in the number of physicians in smaller communities and an increase in their number in larger communities have taken place during the last thirty years.

A questionnaire sent during the war to medical officers on duty with the Army, Navy, Public Health Service and Veterans Administration revealed that most of the men would like to practice in communities of 25,000 or more. Since medical officers were largely younger doctors, it is evident that the tendency for doctors to go to larger cities will continue.

Physicians are limited in number; hence their time must be conserved to the utmost. Each physician should spend all or nearly all of his working time actually practicing medicine. A physician cannot be considered as discharging his duties effectively when he is spending a large share of his time riding about the countryside making house calls. Efforts must be made to have the patients brought to the doctor, thus increasing his effectiveness.

A number of methods have been suggested for overcoming the defect, such as physicians holding office hours several times a week in smaller communities, bus service to large medical centers, "trailer medical care" and improved diagnostic and hospital facilities in smaller communities. From studies of the distribution of physicians according to various economic conditions in communities it may be concluded that the distribution of physicians' services is influenced by some of the factors that determine trade.

It should not be hastily assumed from this that doctors will go only where they make the most money. Many physicians have left smaller communities in which they had lucrative practices to live in larger cities so that they could have adequate hospital facilities, the association of other doctors and better cultural conditions for their families.

Medical Plans Approved

Medical service plans have received favorable consideration by many state medical societies and by the house of delegates of the American Medical Association. All of us recognize the value of insurance to spread risks. Satisfactory medical service plans should enable the patient to receive and the physician to give better medical care just as Blue Cross plans make it easier for the insured patient to go to the hospital.

The public has become conscious of the alteration in medical care. Frequently the doctor is asked, even when some trivial illness is involved, "Why can't I go to the hospital?" The success of Blue Cross has increased hospitalization greatly, and

all of us are aware that this has meant better medical care.

In a consideration of medical service plans some thought must be given to the likely increase of services that will be demanded of doctors, and adequate precautions must be taken so that the quality of medical service does not deteriorate. On the whole, however, any plan that brings more people to the doctor will doubtless result in better medical care.

The success of any plan to provide better medical care is dependent on the willingness of the public to accept medical care. Improved methods of educating the public about the benefits of modern medicine are vital in the success of any program providing more adequate medical care. Radio programs, public lectures and publications are useful means of creating public interest in medical affairs.

Finally, all physicians, hospital people and workers in related fields can assist by taking an attitude of creative leadership in the provision of adequate medical care. With such leadership, the public can be made more aware of medical problems and more receptive and appreciative of good medical care.

Estrogenic Hormone: *Its Evolution; Clinical Applications; the Need for Caution*

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SINCE the fundamental work by E. Allen and E. A. Doisy (1923, 1924) which led to the recognition of a potent substance (estrogenic hormone) formed by the cells of the follicle, an avalanche of investigation has been carried on by numerous workers to seek new and more readily obtainable sources of substances containing the estrogenic principle and also to devise a critical basis for their assay which would permit their ultimate clinical use.

By the turn of the nineteenth century significant advances in the study of the ovary has been made relative to ovogenesis and attendant cytological features; however, many problems in reproduction remained which were still unanswerable. A few investigators began to view the ovary as an organ of internal secretion, a function intimately associated with egg production. Of these few, the name of Emil Knauer is notable. In 1896 he removed the ovaries of guinea pigs and grafted fragments back into the same animal. He observed that such fragments effectively prevented the characteristic atrophy of castration.

Provided Impetus for Research

In 1900 Josef Halban proffered a hypothesis based on his investigations, which provided the proper impetus for productive research on the ovary as an important endocrine organ. He observed that grafted bits of adult ovaries in infantile guinea pigs caused a rapid growth of their uteri to adult size. This led him to conclude that the ovary provides an internal secretion which has a marked, specific action on the reproductive system and other associated organs, such as the mammary glands.

During the closing years of World War I and immediately following, C. R. Stockard and G. N. Papanicolaou (1917 to 1919) made the significant discovery that intra-ovarian conditions can be accurately ascertained by the vaginal test. This discovery not only provided an easier means for correlating organ and tissue responses with follicular ascendency and decline, but also provided a better opportunity to study the overt responses of the intact animal in various phases of the estrous cycle.

It soon became apparent that the estrous phenomenon in a variety of animals was strikingly similar. Moreover, the rapid growth of ovarian follicles was found to be correlated with vascular engorgement and general hyperplasia of the uterus and a notable enlargement of the mammary glands. Leo Loeb in 1917 postulated a secretory rôle to the follicles, which he believed was responsible for the cyclic changes in the uterus.

The final answer, however, was provided by E. A. Doisy, who laboriously collected follicular fluid from the sow ovary and demonstrated conclusively that a few drops of this fluid could produce a normal estrous cycle when injected into castrated rats and mice.

Adopt International Standard

L. C. Kahnt and E. A. Doisy (1928), employing the use of castrated rats and the vaginal test as an indicator, provided a reliable assay for substances suspected or known to contain the estrogenic principle. Finally, in 1932, the London Conference on Biological Standardization of the League of Nations adopted the hydroxy-ketonic form of the estrous-producing hormone, normally obtained from the urine of pregnancy, as the international standard.

Chemically, estrogenic hormone is designated as a sterol of known structure. The minute quantities which Doisy obtained from the sow follicles were revealing in their action and represented a significant contribution; however, the difficulty

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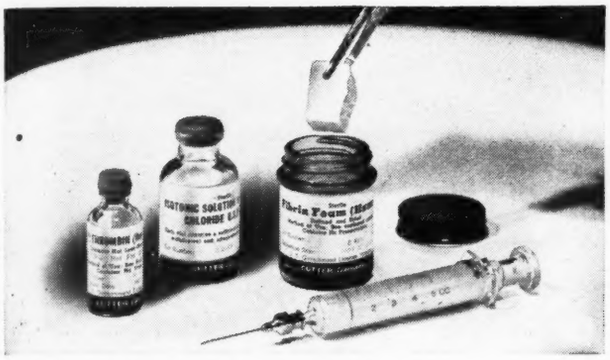

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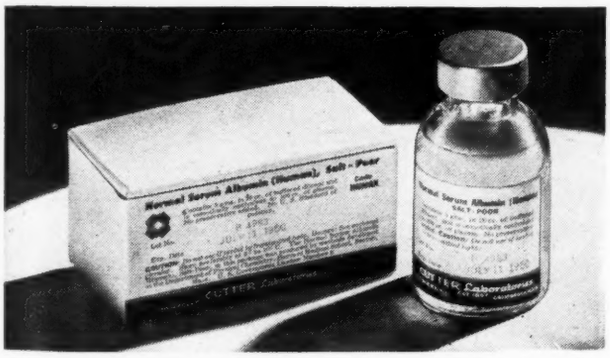
IMMUNE SERUM GLOBULIN*... for measles modification. The gamma-globulin fraction of pooled normal adult plasma, Cutter's Immune Serum Globulin is 20 times as potent as the original human serum. This small dosage volume is relatively non-reactive, and highly effective.



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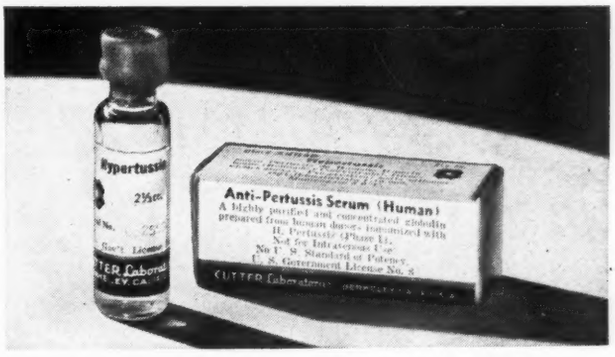

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Cutter Laboratories, Berkeley, California

in obtaining these samples would have produced a real bottleneck in the course of estrogen investigation had it not been for the discovery of Ascheim and Zondek that large quantities of this hormone are secreted by the kidneys in pregnancy.

As a result, urine of pregnancy of the mare today represents the most abundant natural source for commercial preparations of estrogens. The process of recovery of this valuable hormone from the watery secretions of the kidney is immeasurably easier from the chemists' standpoint than is recovery from the follicle. A pure crystalline form of this hormone is now routinely prepared.

The efforts of the biochemists have produced a long series of synthetic products which contain potent estrogenic properties. The most important of these is diethyl stilbestrol. Commercial drug houses have developed and made available for clinical use a number of estrogenic preparations of established potency. Some of these preparations are from natural sources, while others are of the synthetic variety.

The well-known symptoms of natural and surgical menopause have long been difficult to deal with. Regardless of the particular circumstances that deprive a patient of ovarian function, the marked vasomotor disturbance, psychic imbalance and changes in secondary sexual characteristics represent very real problems. Estrogen therapy has been recently used with considerable success in easing these symptoms following ovarian loss.

In many instances stubborn and complicated cases of primary and secondary amenorrhea respond to estrogens. Amenorrheal and climacteric symptoms respond more readily to estrogen therapy when accompanied by some progesterone. Ordinarily, the first few weeks of therapy require a potency of several thousand international units two or three times a week. When the symptoms are brought under control, the number of units is reduced to a level just sufficient to maintain the patient.

Zondek found that tinctures of the hormone were readily absorbed through the skin. He noted that after initial heavier doses were administered by injection, inunction of such tinctures was sufficient to maintain the patient.

Routes of Administration

The early administration of estrogenic hormone was accomplished almost exclusively by hypodermic injection in an aqueous or oil solution. More recently other routes of administration have proved effective. Oral administration appears to be least desirable. Suppositories, nasal sprays, pessaries and ointments containing a specified potency of estrogen are now available. The latter are indicated where local effects are desirable, whereas hypodermic injection is employed for systemic effects.

It has long been known that estrogenic hormone produces a marked growth of the vaginal epithelium. Recognition of this feature has led to a more satisfactory treatment of gonorrheal vaginitis in children. The vaginal epithelium in children prior to puberty is often poorly developed and scanty. Employment of estrogen therapy causes the epithelium to grow more rapidly to a more mature and resistant type and thereby prevents invasion of the organism into the soft underlying connective tis-

sue. Vaginal suppositories containing the hormone are said to effect the desired vaginal changes without excessive systemic results.

Ordinarily, the female breasts begin to develop with the onset of puberty. Such development, of course, is a result of the periodic production of ovarian follicles and their associated hormone. Frequently, varying degrees of hypogonadism result in arrested breast development. Mammary development responds when the deficiency in estrogen is supplemented systemically or by local inunction. Knowledge of the cosmetic value of fully developed breasts to many women, aside from the values of hormone balance in health, has stimulated the incorporation of estrogens in some cosmetic creams.

A condition known as atrophic rhinitis, in which the soft lining of the nasal cavities undergoes degeneration, has been treated successfully by estrogen therapy. Nasal sprays for topical treatment are said to be of therapeutic value. There appears to be a curious relation between the nasal mucosa in some women and the cyclic changes of the uterus. Such individuals suffer from nose bleed, as well as general nasal congestion, in the premenstrual period. Estrogen therapy aids in relieving these symptoms.

It is interesting to note that male disorders may also be benefited by estrogen therapy. There is evidence that the cells of prostatic carcinoma are dependent for their continued existence on the male hormone. Surgical removal of the testes for the purpose of reducing this sustaining factor has proved beneficial. Diminution of the male hormone brings about fatty degeneration of the carcinoma cells and, at the same time, inhibits metastases. Administration of an estrogenic preparation alone or following castration has been shown to be of considerable value. Estrogenic substances counteract the male hormone biochemically and, in certain instances, may obviate the need for surgical castration.

Estrogen therapy has been reported useful in a number of other conditions, such as senile vaginitis, kraurosis vulvae, suppression of lactation and otosclerosis.

Caution Must Be Used

Experimental evidence indicates that a degree of caution should be exercised in the use of estrogenic hormone until more information is available regarding the entire active scope of this powerful substance.

One fact figures prominently in its use, namely, that of selective growth stimulation. Uterine hyperplasia stimulated by estrogenic hormone is impressive. It must be remembered that the vagina, mammary glands and other previously mentioned organs share in this growth response, but to a lesser and limited extent. The delicate balance in rapidly growing tissues between that which is recognized as normal and that which is abnormal is often not well defined. At present there is experimental evidence which cannot be disregarded. This evidence strongly suggests that estrogens may be carcinogenic in certain animals with a natural tendency toward tumor formation.

On the other hand, low tumor strains in general show little or no increase in tumor development following estrogen administration. The matter becomes pertinent when

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FREEDOM FROM SIDE ACTIONS. Since it is absorbed in toto, probably from the stomach, Digitaline Nativelle produces virtually no nausea and vomiting due to local action. Adequate dosage may thus be given without fear of gastric upset, an important point in patients with congestive heart failure.

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Physicians are invited to send for samples, literature and bibliography

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estrogen therapy is indicated for a patient. Since individuals and populations cannot be bred or segregated for selective breeding, as in the case of laboratory animals, the disposition of a given patient to this hormone should be given the closest scrutiny. As yet, no conclusive evidence has been offered which shows that the growth-promoting feature of estrogenic hormone actually hastens the development of an abnormal growth already present. This problem, however, is receiving continued investigation.

The behavior of the pituitary gland following chronic estrogen administration is worthy of consideration. Zondek observed a progressive enlargement of the pituitary gland in his animals after several months of estrogen injection. The enlargement of the gland was due simply to an increase in the normal tissue constituents many times beyond normal limits. The ultimate drastic effects caused by increased intracranial pressure were just as lethal as though the growth consisted of abnormal tissue. Animals receiving the hormone percutaneously also developed similar pituitary tumors.

Continued experimentation will undoubtedly reveal more clinical uses for the estrogenic hormone and, at the same time, will more clearly segregate its real and potential harmful effects.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

A New Cystoscope

Dr. Thomas I. Kirwan, in the February issue of the *Journal of Urology*, gives us an interesting description of a newly developed cystoscope. We are reminded that attempts to devise a means of illuminating the urethra and bladder so that they might be inspected were made at the beginning of the nineteenth century. It was not, however, until 1879 that the Nitze-Leiter cystoscope was presented to the urological world. This early instrument was referred to as "complicated, cumbersome and delicate." During World War I Leo Buerger further modified the Tilden Brown instrument. This was known as the Brown-Buerger cystoscope. Important improvements and additions to cystoscopic instruments were made by Hugh H. Young and by Joseph F. McCarthy.

The author tells us that with the generous and intelligent aid of Frederick J. Wallace he set out to develop a cystoscope that would embody several new features. Because this new cystoscope is boilable, perfect sterilization is assured. The optical elements of the lens system have been modified by coating air glass surfaces with a low reflection film, so that the amount of light transmitted has been increased 100 per cent.

A flexible beak has been added to facilitate introduction of the instrument. The beak is constructed on a ball socket pivot, thus permitting its free movement in either concave or convex positions. This minimizes the danger of creating false passage. The sheath has double fenestra. The telescope can be rotated through an angle of 180°. The size of the water intake and outflow has been increased. An improved design of stopcock has been added. A modification of the locking system has been added to assure union of the telescope to the sheath, thus preventing water leakage. An obdurator has been designed to fit snugly into the sheath filling both fenestrae.—JOHN F. CRANE.

Food Service Equipment Preferred

How do the choices expressed by hospital heads and architects compare with your own preferences?

EVERETT W. JONES

IN THESE days there is considerable democracy in working up plans for new buildings or for remodeling jobs, and the dietitian's experience should be called into play in the preliminary stages of planning for food service and kitchen areas.

Anticipating the tremendous volume of new construction and of expansion of present facilities that is now getting into swing, The Modern Hospital some months ago sent out questionnaires to a cross section of hospital administrators and hospital architects to learn their present preferences in regard to the major elements and items of building construction and equipment.

These preferences are the subject of a series of articles some of which are of intimate interest to dietitians. This article deals with the administrators' and architects' choices on types of fuel, types of food service for patients, employes' food service and sinks. In the March issue, page 120, dietitians will be interested in the returns of the questionnaire relating to refrigeration.

Should we cook with gas or with electricity? What type of transportation system for getting food to patients is the most satisfactory? Should we provide mechanical dishwashing in the very small hospital?

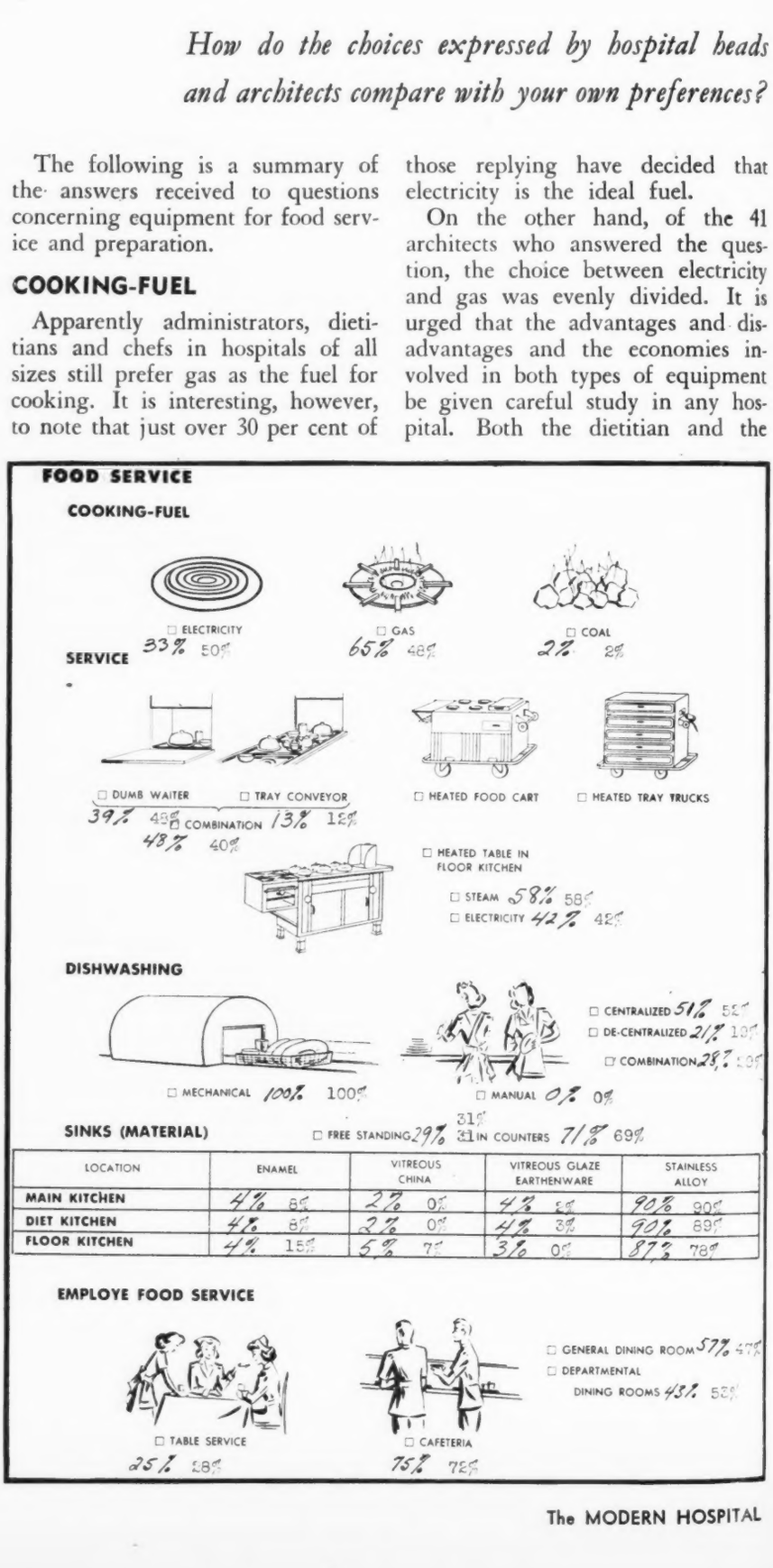
Let's see what the administrators' and architects' preferences are on these matters and compare them with our own views. Perhaps it is not too late to make some changes in building plans if our opinions are corroborated by majority opinion in this survey. On the other hand, majority opinion may not serve our setup because of our peculiar location and circumstances.

The following is a summary of the answers received to questions concerning equipment for food service and preparation.

COOKING-FUEL

Apparently administrators, dietitians and chefs in hospitals of all sizes still prefer gas as the fuel for cooking. It is interesting, however, to note that just over 30 per cent of those replying have decided that electricity is the ideal fuel.

On the other hand, of the 41 architects who answered the question, the choice between electricity and gas was evenly divided. It is urged that the advantages and disadvantages and the economies involved in both types of equipment be given careful study in any hospital. Both the dietitian and the



LOCATION	ENAMEL	VITREOUS CHINA	VITREOUS GLAZE EARTHENWARE	STAINLESS ALLOY
MAIN KITCHEN	4% 8%	2% 0%	4% 3%	90% 90%
DIET KITCHEN	4% 8%	2% 0%	4% 3%	90% 89%
FLOOR KITCHEN	4% 15%	5% 7%	3% 0%	87% 78%

chef should seek the opportunity to express their opinions.

METHOD OF SERVICE

An analysis of the questions on dumb-waiters, conveyers, heated bulk food trucks and heated tray trucks does not disclose any clear-cut preferences. Many hospitals, because of different physical layouts in various sections of the building, must use a combination of two or three types of transportation to deliver meals to patients.

At Albany Hospital, Albany, N. Y., heated bulk food carts were used to deliver food from the main kitchen to the central tray serving stations. Dumb-waiters originating in these stations delivered the fully prepared trays to two equally spaced locations on all floors of three wings in the main multistoried building. The same system was used to deliver trays to both floors of two adjacent two story ward pavilions.

It was necessary, however, to send the heated bulk food carts directly to each floor of a two story pavilion building at some distance from the main kitchen. If more central serving station space in connection with the main kitchens had been available, the trays for this remote pavilion probably would have been prepared in the central serving stations and heated tray trucks would have been used for delivery.

Many hospitals with similar combinations of old and new buildings must work out the best combination of food delivery systems and equipment to meet their particular conditions. Many authorities believe that every effort consistent with the ability to serve hot foods hot and cold foods cold should be made to develop a highly centralized food service.

Experience has pretty well proved the economies of centralized service although in a highly centralized service based on dumb-waiters and/or tray conveyors, the problem of working special diet trays into the production line is a difficult one. Heated tray trucks are sometimes of great help in serving special diet trays.

In an old hospital, particularly in one that is laid out on a horizontal transportation basis, heated tray trucks often provide the solution to the problem of installing centralized food service.

Opinions of Hospital Executives and Architects on Food Service Equipment

Type of Equipment Desired	*General Hospitals* 40 to 99 beds	100 to 249 beds	250 beds and over	*Psychiatric and Tuberculosis Hospitals All Sizes*	*Architects*
Number of Answers	47	44	28	23	41
Cooking Fuel					
Electricity	15	17	12	7	24
Gas	30	30	23	16	23
Coal	1	..	..	2	1
Service					
Dumb-waiter	6	7	8	9	12
Tray conveyor	5	4	1	..	3
Combination	16	9	8	4	10
Heated food cart	16	22	22	18	21
Heated tray trucks	22	12	7	10	19
Heated table in floor kitchen	10	17	12	8	14
Steam	13	15	10	9	15
Electricity	14	11	5	4	11
Dishwashing					
Centralized	17	21	10	8	14
Decentralized	..	6	8	9	5
Combination	11	8	7	4	8
Mechanical	34	38	22	18	40
Manual	..	..	..	..	..
Sinks					
Free standing	5	1	5	4	4
In counters	10	11	8	7	9
Material for Sinks					
Main Kitchen					
Vitreous china	3	..	..	..	..
Enamel	2	3	..	..	5
Vitreous glaze earthenware	1	1	1	2	1
Stainless alloy	34	39	27	22	36
Diet Kitchen					
Enamel	2	3	..	..	5
Vitreous china	3	..	..	..	..
Vitreous glaze earthenware	1	1	1	2	1
Stainless alloy	34	38	27	19	34
Floor Kitchen					
Enamel	2	3	..	..	6
Vitreous china	5	2	..	..	3
Vitreous glaze earthenware	1	..	2	1	..
Stainless alloy	31	37	25	15	32
Employe Food Service					
Table service	12	8	10	7	11
Cafeteria	31	37	22	19	28
General dining room	23	21	18	13	17
Departmental dining rooms	13	22	12	10	19

If there are still hospital administrators left who do not appreciate the curative values and public relations stimulus inherent in really good meals, they should be educated at once. Despite the fact that a vast majority of administrators does appreciate these facts, there are still far too many complaints from patients in all types and sizes of hospitals in all parts of the country.

Far too often, hospital trustees criticize the administrator or dietitian because of complaints in the community of cold food in the hospital and then fail to provide money for the equipment which the administrator and dietitian have been asking for to cure the conditions responsible for the patients' complaints.

DISHWASHING

One hundred per cent of the answers to the dishwashing question called for mechanical dishwashing equipment. There are, however, still many small hospitals and some medium-sized hospitals using hand methods for dishwashing. Why any

hospital still tolerates the waste of employe hours and bad sanitary conditions inherent in hand dishwashing is difficult to understand.

SINKS

A glance at the summary of preferences as to material for sinks of all kinds shows an overwhelming preference for stainless alloy metal. Considering the long life expectancy and ease of cleaning of this type of sink, the replies to this question are not surprising.

EMPLOYE FOOD SERVICE

On the subject of food service facilities for employes, cafeteria service seems to be the most popular choice. With the inevitable and rapidly increasing trend toward all cash salaries and wages for hospital employes, allowing them to buy as little or as much maintenance from the hospital as they want, it is probable that pay cafeterias will be more widely used in hospitals. Evanston Hospital at Evanston, Ill., is one of the small but growing number of institutions that has cafeteria service with all employes of all departments eating in one big dining room. This experiment in real democracy has been highly successful.

SUPERVISION

A final word to administrators and dietitians on food service to patients: Although well-planned and well-equipped food preparation and service units are essential to the serving of attractive, palatable meals, no amount of equipment will guarantee high-grade food service without well-trained, food conscious personnel. Hospital administrators need to give a great deal of thought and supervision to the dietary department.

During the meal serving periods, everyone in the dietary and nursing departments must concentrate on the serving of meals. Attending physicians and the house staff must not (except in emergencies) be allowed to interfere with meal service. Rigid time schedules for the serving of meals must be worked out and adhered to. Nursing department employes must have bedside or overbed tables cleared and in position to hold trays. Patients must be ready on time.

The hospital administrator and his assistants, the chief dietitian and her staff, the director of nurses and her administrative assistants, supervisors and head nurses must cooperate in making supervisory rounds at mealtimes. Friendly but strict and continuing supervision from the top will go a long way toward improving the standards of food preparation and service.

It should never be forgotten that all three legs of the tripod are essential to proper and accurate leveling of the hospital's sights if meals are to help sick patients get well:

1. Capable and friendly checking up at all supervisory and administrative levels.
2. Carefully selected, well-trained and happy employes.
3. Use of high-grade equipment for food preparation and service.

In a later issue of the magazine, but not in this department, the preferences of hospital administrators and architects on floors, ceilings, walls and wainscots will be enumerated. Since kitchens are included, dietitians will want to watch for this article.

The Quartermaster Corps knows that

Leftovers Make Good Meals

THE clean plate and the empty serving container, these should be symbols of American cooperation in the task of feeding the starving peoples of Europe and other war-ravaged areas of the world.

War food shortages, coupled with careful menu planning, have done much to reduce the vicious waste that often is the result of leftovers. In most cases leftover food is merely an index of careless planning. However, there are extenuating circumstances and the important point is not to permit leftover foods to be thrown out immediately or to deteriorate and have to be thrown out eventually.

"Any successful dish can be made into something as good or even better the second time" was the comment of a shrewd and cheerful mess sergeant at Camp Lee, Va., where during the war a Leftover Clinic was conducted, attended by cadre cooks, mess sergeants and instructors in the cooks', mess sergeants' and mess management school.

So successful were these sessions of the Leftover Clinic that Maj. Harvey C. Cluff, the post food service supervisor, issued a booklet on "Use of Leftovers" from which the Office of the Quartermaster General permits quotations for the benefit of hospital dietitians and especially for small hospitals without the services of a dietitian.

While most of this is "old stuff," there will no doubt be a few little tricks that old hands in the kitchen may well have forgotten. Some of these dishes are more suitable for feeding the personnel than for feeding the patients.

BEVERAGES

Coffee: Use for (1) making coffee gelatin; (2) iced coffee; (3) mocha frosting (part chocolate and part coffee); (4) cake flavoring (as part of liquid in chocolate mocha cake); (5) coloring.

Tea: (1) Use for iced tea; (2) combine with leftover lemonade for fruit flavored iced tea.

Cocoa: (1) Use as iced cocoa; (2) keep and reheat in double boiler; (3) use as flavoring in bread pudding; (4) use in chocolate pudding, frosting or filling, decreasing recipe amounts of chocolate, milk and sugar to justify the amount used.

Fruit Juices: (1) Use for fruit ade made with a combination of flavors; (2) breakfast juices; (3) coloring for frostings, fillings and beverages (applies to berry juices only); (4) part of liquid for mincemeat; (5) flavor and juice for fruit pies (mixtures are good, such as cherry juice in berry pie, apple juice in cherry and berry pies, citrus juices in any fruit pie); (6) fruit sauce for puddings (made with juice, pieces of fruit, flavoring, spices and cornstarch); (7) pudding moistener and flavorer; (8) addition to gelatin for salads and desserts.

Citrus Fruit Ades: (1) Combine with new fruit drinks; (2) add to fruit juices for fruit ades; (3) add small amount to fruit cocktail; (4) use as liquid in gelatin salad.

FRUITS

Fruits: (1) Salads; (2) fruit cocktails; (3) fruit sauce for cottage pudding and other puddings; (4) pie fillings (applesauce with rhubarb; raisins with cranberries, prunes and apricots); (5) chop to flavor frostings; (6) cake and pastry fillings (fruit, liquid, sugar, spices, cornstarch); (7) puddings (add diced fruit to bread pudding, rice pudding, etc.); (8) mincemeat; (9) tarts and turnovers (small pastries made with regular batch to use up leftovers); (10) fruit filling for raised doughs; (11) cake icing (add chopped fruit that has been cooked first but do not destroy consistency of icing); (12) gelatin salads and desserts; (13) fritters; (14) Brown Betty; (15) applesauce or pumpkin cake*; (16) fruit filling for coffee cake and rolls.

SAUCES AND GRAVIES

1. Save excess natural drippings for a later meal when rich gravy can be used to garnish a meat pastry dish or meat loaf.
2. For spiced gravy: reheat leftover gravy over low heat, seasoning it with vinegar and sugar, allspice and clove; add leftover meat slices and serve.
3. Make barbecue sauce.
4. Use as moistener and binder for meat loaves and hash.
5. Transform gravy into sauce by adding lightly fried chopped onions, carrots and green peppers.
6. Add tomato sauce to gravy for new sauce.
7. Add drippings or gravy for thick soups.
8. Add them to dressing as a moistening agent.
9. Add them to chile con carne meat mixture.
10. Reheat gravy and serve as it is.
11. Use it to baste pot roast in braised meat dishes.
12. Use it in casseroles and escalloped dishes instead of cream sauce.

STUFFING AND DRESSING
(Always use at next meal)

1. Grind and use as filler or binder for meat mixture.
2. Reheat with meat slices or dice in casserole style, moistened with gravy or stock.
3. Transform plain dressings by adding new flavorings, such as cooked sausage, chopped meat, onion, chopped oysters, chopped celery.
4. Use in stuffed pork chops.
5. Use with leftover meat slices for veal birds.

MEAT MISCELLANY

Liver: (1) Grind for liver loaf; (2) use diced with creole sauce; (3) mix in small proportions with other ground meats; (4) serve spaghetti with liver (grind liver, season with sautéed onion, green pepper and celery; add to seasoned and cooked

tomatoes to make a rich sauce to pour over spaghetti).

Tongue: (1) Used as cold cuts; (2) slice or dice and serve with creole sauce; (3) mix with other meat for grinding; (4) garnish for greens.

Baked Heart: (1) Grind with other meats; (2) use in meat loaf.

Chop Suey: (1) Use to make egg fu jung*; (2) use in meat loaf.

Stuffed Pepper: Grind and use as flavoring ingredient in other ground meats.

Chile con Carne: Reheat and serve in Texas Tacos.*

MACARONI, SPAGHETTI, NOODLES, RICE, CEREALS

1. Fillers and extenders; it is not necessary to grind rice.
2. Macaroni, spaghetti or noodles with cheese.
3. Casserole with meat, macaroni and spaghetti especially.
4. Escalloped macaroni and seafood.
5. Addition to soups.
6. Spanish rice.
7. Curried rice.
8. Rice pudding.
9. Rice au gratin (rice in cheese sauce, seasoned with red pepper, salt, with grated cheese and bread crumbs).
10. Rice fritters.
11. Rice and creamed dishes or gravy.
12. Rice in meat casseroles: layers of rice alternating.
13. Noodles with creamed spinach, peas or vegetables au gratin.
14. Macaroni or spaghetti salad.
15. Chopped noodles, macaroni, spaghetti or rice as potato substitute in stews.

Oatmeal: (1) Cookies; (2) filler, fried and served with sirup and butter; (3) hold under refrigeration and reheat in double boiler, adding necessary moisture to re-serve it; (4) use small quantity as binder in all types of ground meat.

Cornmeal: (1) Texas Tacos*; (2) fried cornmeal mush with sirup and butter; (3) layers of cooked cornmeal in casserole meat dishes with tomato sauce; (4) muffins; (5) corn bread; (6) use small quantity as binder in all types of ground meat.

Hominy Grits: (1) Reheat with diced fried bacon added; (2) use small quantity as binder in all types of ground meats.

BEANS (cooked, dry) AND HOMINY

Baked Beans: (1) Soup, pureé and add stock; (2) sandwich spread (grind, add minced celery and onion and moisten with dressing or catchup); (3) salad (mix with mayonnaise and diced celery, a little minced onion and pickles; possibly catchup); (4) croquettes; (5) filler for meat mixtures; (6) baked bean loaf (alternate layers of beans, sliced onion and tomatoes, baked in moderate oven, possibly with cheese); (7) baked beans and hominy, mixed and heated; (8) cheese-bean roast.*

Lima Beans (dry): (1) Succotash; (2) ham and lima bean casserole, with plenty of juice from added stock, soup, tomatoes and possibly grated cheese; (3) baked with diced or ground meat; (4) soup, adding hot seasoned stock; (5) filler; (6) cheese-bean roast.*

Kidney Beans: (1) Chili con carne; (2) casserole with diced or ground meats; (3) crush, season highly and make into thick sauce by

adding tomatoes and pour over Texas Tacos*; (4) soup; (5) bean and meat loaf with creole sauce; (6) filler; (7) cheese-bean roast.*

Hominy: (1) Ham and hominy casserole; (2) hominy and baked beans; (3) fried hominy and diced bacon; (4) filler; (5) hominy and tomatoes; (6) in vegetable loaves (whole kernels or ground).

Recipes for the dishes marked with an asterisk follow. These also are from the Army's booklet on leftover foods and perhaps the portions indicated will be too hearty for indoor workers.

Applesauce or Pumpkin Cake

Yield: 250 Servings

10½ pounds sugar
3 pounds 12 ounces shortening
3 ounces salt
2¼ ounces allspice
1½ ounces soda

Cream the foregoing ingredients together until smooth.

50 eggs

Add slowly to mixture.

10¼ pounds applesauce or pumpkin puréed

To this add the following:

7 pounds flour
2 pounds cornstarch
3 ounces baking powder, sifted

Mix the flour in lightly. Pour 6 pounds of batter into each sheet pan. Bake in a moderate oven.

Egg Fu Jung

Yield: 50 Servings

Beat from 75 to 100 eggs until light. Add leftover chop suey, extended if necessary with chopped leftover meat or a sautée of onions and celery. Fry on hot griddle. May be served with a sauce or plain.

Texas Tacos

Mix cornmeal with water and salt to taste to make a thick batter. Spoon onto hot griddle to make cakes, browning on both sides. Cover cakes in bake pan with leftover chile con carne (or fold over cakes stuffed with meat); bake in oven until piping hot. Serve with Mexican hot sauce or tomato sauce.

Mexican Hot Sauce

Yield: 3 Gallons

Step 1. Grind and sautée the following:
3 pounds onions
5 pounds celery
½ pound green pepper
¼ pound clove of garlic

Step 2. Mix with foregoing vegetables:
8 pounds ground cooked meat

Step 3. Season meat mixture with:
1 ounce allspice
½ pound chili powder (or to taste)
1 teaspoon ground mustard (to taste)

Step 4. Simmer for one hour on a slow fire:
3 No. 10 cans tomatoes
Juice of 2 lemons or ½ cup vinegar

Step 5. Add meat mixture to tomato sauce. Simmer on very slow fire for two or three hours. Serve over cornmeal cakes, frankfurters, meat roll.

Cheese-Bean Roast

Step 1. Put through food chopper:
4¾ quarts leftover baked kidney or lima beans
10 pounds cheese

Step 2. Sautée onions in fat:
24 onions
¾ pound butter, bacon fat or shortening

Step 3. Beat the following number of eggs well, add seasoning and then add beans and cheese. Mix well.
50 eggs
3 tablespoons salt
1 tablespoon pepper
½ tablespoon paprika

Step 4. Mix in well:
2½ pounds fresh bread crumbs

Step 5. Put in greased pans or shape into patties or croquettes. Bake for from forty to fifty minutes.

Step 6. Serve with tomato sauce.

Menus for May 1946

Mildred A. Flye
Laconia Hospital
Laconia, N. H.

1
Stewed Rhubarb
Poached Egg on Toast, Bacon
•
Baked Ham With Raisin Sauce
Whipped Potatoes
Baby Lima Beans
Sliced Tomatoes
Snow Pudding With Melba Sauce
•
Vegetable Chowder
Chicken Shortcake
Orange and Date Salad
Mocha Cupcakes

2
Sliced Oranges
Bacon
•
Cream of Mushroom Soup
Broiled Steak
Mashed Potatoes
Green Peas
Fresh Strawberry Shortcake With Whipped Cream
•
Grapefruit Juice
Cheese Fondue
Hot Rolls
Celery and Olives
Applesauce
Gingersnaps

3
Apricot Nectar
Scrambled Eggs, Muffins
•
Steamed Haddock With Anchovy Sauce
Volcano Potatoes
Fresh String Beans
Harvard Beets
Buttercrunch Ice Cream
•
Salmon Salad
Potato Chips
Hot Cloverleaf Rolls
Pineapple Ambrosia
Arrowroot Cookies

4
Sliced Bananas
Bacon, Toast
•
Tomato Juice
Roast Beef and Gravy
Baked Idaho Potatoes
Summer Squash
Cherry Cobbler With Whipped Cream
•
Consommé
Toasted Crackers
Fresh Asparagus With Hollandaise Sauce
Pears
Sugar Cookies

5
Fresh Strawberries
French Toast, Maple Sirup
•
Cranberry Juice
Broiled Duckling
Candied Sweet Po atoes
Green Peas Maître D'Hôtel
Vanilla Ice Cream, Butterscotch Sauce
Cookies
•
Cream of Tomato Soup
Assorted Sandwiches
Jellied Fruit Salad
With Whipped Cream
Chocolate Cake

6
Stewed Prunes
Scrambled Ham and Eggs
•
Roast Lamb With Gravy
Parsley Potato Balls
Spinach
Corn Niblets
Rhubarb Betty With Raisins
•
Macaroni Mousse
Hearts of Romaine With Chili Dressing
Black Bing Cherries
Coconut Cookies

7
Grapefruit Juice
Poached Eggs on Toast
•
Cream of Mushroom Soup
Broiled Liver and Bacon
Mashed Potatoes
Lettuce With Russian Dressing
Fresh Pineapple Sponge
•
Cold Cuts
Pittsburgh Potatoes
Carrot Sticks and Celery Curls
Peach Sauce
Daffodil Cake

8
Sliced Bananas
Scrambled Eggs and Ham
•
Cherry Juice
Chicken à la King in Patty Shells
Buttered Baby Lima Beans
Green Salad
Strawberry Shortcake With Whipped Cream
•
Scotch Broth, Crackers
Pecan Rolls
Fresh Fruit Plate, Cream Cheese Balls
Chocolate Custard

9
Stewed Apricots
Bacon, Cinnamon Rolls
•
Meat Stew With Baking Powder Biscuits
Celery Ring
Carrots and Peas
Fruit Bavarian Cream
•
Consommé
Chicken Stuffed Tomato Salad
Hot Parker House Rolls
Potato Chips
Fresh Pineapple Cake

10
Apple Juice
Poached Eggs on Toast
•
Cream of Celery Soup
Fish With Baked Tomatoes
Mashed Potatoes
Spinach
Chocolate Éclairs
•
Cheese and Noodle Loaf With Mushroom Sauce
Orange and Grapefruit Salad
Spice Cake With Baked Frosting

11
Stewed Rhubarb
Scrambled Eggs
•
Baked Ham With Pineapple Rings
Candied Sweet Potatoes
Summer Squash
Buttered Beets
Orange Sponge Pudding With Orange Sauce
•
Creamed Chipped Beef
Baked Potatoes
Fresh Strawberries and Cream
Icebox Cookies

12
Apple and Pear Juice
Bacon, English Muffins
•
Roast Turkey, Giblet Gravy
Mashed Potatoes
Cranberry Sauce
Celery Hearts, Olives
Corn Niblets
Coffee Ice Cream
•
Split Pea Soup, Croutons
Assorted Sandwiches
Fresh Fruit Cup
Devil's Food Cake

13
Sliced Oranges
Soft Cooked Eggs
•
Pot Roast of Beef With Gravy
Oven Browned Potatoes
Sliced Tomatoes
Carrots
Pineapple Upside-Down Cake
•
Vegetable Soup
Fresh Asparagus on Toast With Cheese Sauce
Bananas and Cream
Hermits

14
Fresh Strawberries
French Toast, Maple Sirup
•
English Beef Broth
Roast Lamb With Gravy
Mint Jelly
Volcano Potatoes
String Beans
Angel Cake Supreme
•
Macaroni and Chipped Beef
Jellied Tomato and Asparagus Salad
Pears
Wafer Thin Chocolate Cookies

15
Stewed Prunes
Soft Cooked Eggs
•
Tomato Juice
Liver and Bacon
Mashed Potatoes
Carrot and Asparagus Salad
Fruit Sherbet
Vanilla Cookies
•
Chicken Loaf With Mushroom Sauce
Potato Chips
Grapefruit and Orange Sections
Sponge Cake

16
Apple Juice
Bacon, Raisin Toast
•
Chicken Shortcake
Buttered Beets
Chef's Salad
Celery
Rhubarb Sauce
•
Vegetable Soup, Toasted Crackers
Cloverleaf Rolls
Fresh Fruit Plate With Cream Cheese Balls
Rainbow Gelatin

17
Sliced Oranges
Scrambled Eggs
•
Baked Haddock Fillets With Muhhroom Stuffing
Escalloped Potatoes
Sliced Tomatoes
Baby Lima Beans
Peach Cobbler With Whipped Cream
•
Cherry Juice
Baked Macaroni and Cheese
Carrot Sticks and Celery Curls
Fresh Pineaple
Macaroons

18
Grapefruit Juice
Bacon, Muffins
•
Cranberry Juice
Roast Stuffed Leg of Lamb Jardiniere
Crusted Potatoes
Buttered Cauliflower
Lemon Sauce Pudding
•
Alphabet Soup
Stuffed Egg and Tomato Salad
Entire-Wheat Rolls
Strawberries With Cream
Delicious Nut Cupcakes

19
Sliced Bananas
Poached Eggs on Toast
•
Steak
Baked Stuffed Potatoes
Green Peas Maître D'Hôtel
Summer Squash
Peppermint Stick Ice Cream
•
Tomato Juice
Buttered Fresh Asparagus on Toast
Orange Salad
Sponge Cake

20
Stewed Rhubarb
Bacon, Muffins
•
Apricot Nectar
Cold Sliced Ham
Potato Salad
Sliced Tomatoes
Glorified Rice Pudding
•
Consommé
Vegetable Soufflé With Cheese Sauce
Peaches
Date and Nut Rocks

21
Grape and Apple Juice
Scrambled Eggs and Ham
•
Roast Beef au Jus
Melting Potatoes
Spinach
Carrots
Strawberry Shortcake With Whipped Cream
•
Cold Cuts
Escalloped Potatoes
Fresh Fruit Salad
Chocolate Chip Drop Cookies

22
Stewed Prunes
Poached Egg on Toast
•
Roast Turkey, Gravy Dressing
Cranberry Sauce
Mashed Potatoes
Corn Niblets
Frenched String Beans
Strawberry Ice Cream
•
Tomato Juice
Welsh Rabbit on Crackers
Pineapple Supreme Salad
Cross Word Puzzle Cake

23
Fresh Strawberries
Bacon, Rolls
•
Hamburger Loaf With Mushoom Sauce
Parsley Potatoes
Buttered Cauliflower
Harvard Beets
Prune Whip Cake
•
Ham à la King on Holland Rusk
Salad Bowl
Black Bing Cherries
Butterscotch Cookies

24
Bananas
Soft Cooked Eggs
•
V-8 Cocktail
Broiled Fillet of Cod With Egg Sauce
Mashed Potatoes
Carrots
Pineapple Tapioca With Whipped Cream
•
Lobster Stew
Salad Bowl With French Dressing
Applesauce
Golden Crown Cake With Cream Cheese Dressing

25
Apricot Nectar
French Toast, Maple Sirup
•
Liver and Bacon
Baked Potatoes
Celery
Lima Beans
Fresh Strawberry Shortcake
•
Chicken Hawaiian on Toast
Jellied Fruit Salad
Date Oatmeal Cookies

26
Stewed Rhubarb
Bacon, Muffins
•
Baked Ham
Sweet Potatoes Georgia
Asparagus
Sliced Tomatoes
Pecan Ice Cream
•
Beef Broth With Rice
Assorted Sandwiches
Celery, Olives
Pickles
Fresh Pineapple Cake

27
Cherry and Apple Juice
Scrambled Eggs
•
Tomato Bouillon
Lamb Chops
Mint Jelly
Volcano Potatoes
Summer Squash
Rhubarb Upside-Down Cake, Whipped Cream
•
Cream of Corn Soup
Parker House Rolls
Apricot, Nut and Cream Cheese Salad
Filled Cookies

28
Sliced Oranges
Bacon, Raisin Toast
•
Meat Stew With Biscuits
Peas
Carrot and Raisin Salad
Strawberry Floating Island
•
Spaghetti and Tomatoes
Lettuce Hearts With 1000 Island Dressing
Mocha Basarian Cream

29
Fresh Strawberries
French Toast, Sirup
•
Cranberry Juice
Roast Chicken, Gravy Dressing
Mashed Potatoes
Buttered Broccoli
Caramel Custard
•
Escalloped Ham and Potatoes
Honey Rolls
Chiffonade Salad
Fresh Pineapple
Butterfly Cake

30
Apple Juice
Bacon, English Muffins
•
Roast Stuffed Leg of Lamb Jardiniere
Volcano Potatoes
Buttered String Beans
Pineapple Upside-Down Gingerbread With Whipped Cream
•
Consommé
Egg and Tomato Salad
Knotted Seed Rolls
Peaches
Pecan Squares

31 Sliced Bananas, Poached Eggs on Toast • Baked Haddock With Piquante Crust, Mashed Potatoes, Salad Bowl, Orange Soufflé With Whipped Cream • Tuna Salad, Potato Chips, Hot Rolls, Fresh Strawberries and Cream, Caramel Cake

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Minimizing Nutritional Loss

AFTER TONSILLECTOMY

During the week or ten days following tonsillectomy, when dysphagia is troublesome and discourages eating, nutritional setback is apt to ensue. Especially in children, during the rapid growth periods, is this reaction likely to become evident.

Few foods can equal the advantages of Ovaltine as an easily swallowed source of nutrients following tonsillectomy. Taken cold, this liquid food supplement is readily accepted by all patients since it produces virtually no local trauma or discomfort.

Made with milk as directed, Ovaltine provides an abundance of essential nutrients as shown in the table of composition. Children enjoy its delightful taste, and drink three or more glassfuls daily without coaxing. Thus Ovaltine provides an effective means of maintaining the nutritional state postoperatively, and merits recommendation for continued use, when the patient leaves the hospital.

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CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Washing Machine Aids Polio Patients

M. K. REYNOLDS
Civil Engineer
Member, Board of Trustees*
St. Luke's Hospital
Marquette, Mich.

MANY hospitals have standardized their treatment of poliomyelitis, in convalescent as well as acute stages, along lines laid down by Sister Kenny.

Her recommended treatment specifies the use of frequently repeated applications of hot moist cloths. If a considerable number of patients is to be served and the recommendations are conscientiously observed, some means must be found to produce these hot packs by production, or at least semiproduction, methods.

The most convenient apparatus for heating cloths in water and subsequently removing most of the surplus water is the family washing machine.

Washing machines are assembly line produced. They offer the greatest possible efficiency and value at the lowest reasonable cost.

If, then, hot moist packs are to be made available in volume, common sense indicates an examination into the possibilities of washing machines, new, old or obsolete, of either the roller wringer or centrifuge type.

I have little knowledge of washing machines in general and am of the opinion that some types and models may not lend themselves favorably for conversion to hot pack production. Nevertheless, those that have come to my attention have presented no serious difficulties and, in some cases, a crude conversion has proved ridiculously simple.

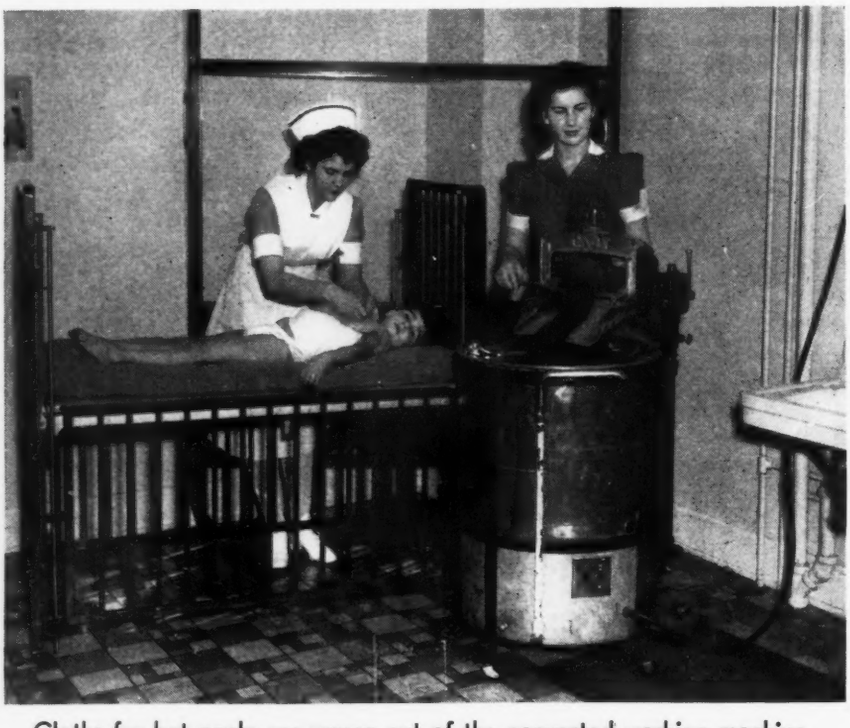
To reiterate: the problem is only one of heating the cloths to the desired temperature and then wringing them out. Owing to the fact that washing machines do not provide the hot water they use, some means must be found to accomplish this end. Four methods suggest themselves and will be discussed: (1) introducing boiling water from some other receptacle; (2) applying heat, from some independent source, to the bottom of the washing machine; (3) incorporating an electric heating unit in the bottom of the apparatus, and (4) introducing live steam into the water, either directly or by passage through a spiral coil permanently installed in the bottom of the tub.

Method 1 is obviously too primitive and laborious to be given serious consideration. Method 2 is dependent on the construction of the machine; it may or may not be practical. Method 3 is ideal and is strongly recommended. However, it requires the most time, engineering, skilled workmanship and expense.

Method 4 is the quickest to accomplish and requires little alteration in the washing machine. It is positive, almost foolproof *if a pressure-reducing valve has been installed,* heats the water with extreme rapidity and involves nothing whatever to get out of order. For a reliable emergency conversion it appears to be the most practical method. It will be necessary only to introduce a spiral copper coil on the inside bottom of the machine and install flanges and nipples so that the live steam may have ingress and egress through the bottom of the machine, through the coil, out of the bottom of the tub and into the return condensed steam line.

The use of this method, of course, is predicated on the availability of sterilizer steam, or other steam under pressure, at stations in the immediate locality where the hot packs must be applied. Rubber steam hose may be used to conduct both the incoming and outgoing steam, but it is

*The author is also a director of the Michigan Society for Crippled Children and Disabled Adults, director of the Bay-Cliff Health Campus and member of the Michigan Crippled Children's Commission.



Cloths for hot packs are wrung out of the converted washing machine. A thermostat imbedded in rock wool insulation is located inside a removable panel. A bull's eye lamp indicates whether heater is on or off.

obvious that the portability of the apparatus is limited to the practical length of such hoses.

St. Luke's Hospital, Marquette, Mich., has converted two washing machines for hot pack production, and a description of these conversions may prove enlightening to anyone interested.

Conversion A is simply a sort of glorified vacuum bottle, with a built-in electric heating unit, something on the order of an electric coffee percolater, with the coffee container removed.

An old model washer having a copper tub 24 inches in diameter was used. All parts that functioned only for washing purposes were removed. A stainless steel tank 16 inches in diameter was inserted into the washer tub. This tank was 3½ inches less in height than the tub to allow for 3 inches of insulation between the two bottoms and half an inch for slope at the top to permit wringer water to run back.

High Temperature Maintained

Insulation consisted of rock wool packed into the annular space between the two tubs and also between their two bottoms. It may prove of interest to note that with the tub heated to 200°F. and the current turned off for fifteen hours, the temperature dropped only 30 degrees.

The heating element used was an immersion-type, 1500 watt, 115 volt hot water heater unit. A surface type of hot water heater thermostat maintained the desired temperature. A metal skirt was installed below the tub to cover the mechanism and to provide a place for the switches and pump control.

In order to eliminate the possibility of burning out the heater by plugging in the cord when the tank was empty, a false perforated bottom was installed just above the heater and a pipe nipple, 3 inches long, projecting up through this false bottom, prevented the pump from exhausting the water to a lower level. Provision was made for a thorough cleaning when necessary.

It was considered desirable to install a power pump to empty the tub and this was done, although it was necessary to adapt one taken from another washer. The outlet pipe from the pump ran clear to the top of the machine; it had a swinging gooseneck which made it possible to exhaust the tub into any convenient receptacle having a regular drain.

The cover was made of two disks of stainless steel, with a 1 inch disk of acoustical material between for insulation. A hinge was provided by redesigning a heavy ice room door hinge in such a manner that the cover could fold clear over the machine and come to rest against a rubber bumper attached to the outside shell.

The power driven, rubber roller wringer was part of the original washing unit and required little or no change.

It was considered desirable, for greater stability, to provide a base with four casters instead of the customary three, and this was done.

This machine has been in continuous operation for eleven months and has rendered excellent service. A few "bugs" were ironed out as they became apparent but the conversion had been carefully thought out, adequately engineered and conscientiously executed. Time was not a matter of paramount importance and a good, sympathetic, cooperative machine shop was available.

Conversion B was an emergency job, for active polio patients were admitted to St. Luke's Hospital and it was considered necessary to install a separate hot pack unit on the isolation floor.

A little scouting unearthed a machine that seemed usable. It was of the centrifugal wringer type and was obsolete; the dealer, who had taken it in trade, turned it over to the hospital for a nominal sum when he was informed of the purpose for which it was to be used.

Most of the day was spent tearing it down, scraping off the time-hardened grease, cleaning, oiling, reassembling, adjusting and effecting a few minor repairs to broken or damaged parts. As the work proceeded the machine seemed almost made to order for the purpose. The 24 inch clothes container was generous enough to serve a number of patients and a foot lift, having a long throw, made it possible to maintain a considerable volume of hot water in the tub and still raise the centrifuge cage well above water level when the clutch, imparting the whirling motion, was thrown in.

Time now being of the utmost importance, none was wasted on insulation or the incorporation of any gadgets for convenience or more efficient operation.

A hole was cut in the bottom of the tub and a flange, accepting a ½ inch pipe nipple, was riveted and soldered in place. Meanwhile, at the hospital, a sterlizer steam outlet had been fitted and provided with a pressure-reducing valve and shutoff.

The machine was transported to the hospital and hooked up to the steam line with a rubber steam hose. Sufficient water was poured into the tub and live steam was admitted. A crackling like machine gun fire ensued, gradually diminishing as the water in the tub heated up. This result had been anticipated but the need was so urgent that it was considered desirable to "bull it through" and to be prepared to clean up all the "bugs" at one time, if other unfavorable manifestations developed.

The cover with which the tub was provided proved most inconvenient. It was cumbersome and had to be removed entirely from the apparatus and placed on the floor when the cloths were to be removed. Furthermore, steam issuing from the large exposed area was most disconcerting and obscured vision.

New Cover in Two Sections

Measurements were taken so that a spiral copper steam coil could be fitted to the bottom of the tub. Measurements were also taken of the cover and a sort of shallow cylindrical cap was made to fit down over the side of the tub and was rendered immovable by three lugs held in place with wing nuts. The top of the cover was made in two parts, the main part having a rolled over edge, in which the second part could be revolved by means of a projecting wooden knob. A large semicircular aperture was cut in each part, much in the manner of an old-fashioned camera shutter, so that when the apertures were in register the hot packs could be removed. To reach any packs that were not accessible under the opening it would be necessary only to move the centrifuge basket with a gloved hand.

At the least inconvenient time the apparatus was removed from the hospital to the machine shop, the changes indicated were quickly effected and the converted machine was put back into service.

At time of writing it had been in operation only a few days, in its im-

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proved condition, but the hospital reported that it was giving an excellent account of itself.

At this point it is well to point out that centrifuges in commercial laundries are securely fastened to heavy concrete foundations. They are carefully packed by persons experienced in their operation and every effort is made to reduce vibration. A badly balanced centrifuge mounted on casters is about as dangerous as a "booby trap," especially when it is partially filled with water at, or near, a boiling temperature.

Hospital administrators who have only a vague notion of the effort involved in the conversion of a washing machine to a hot pack machine will naturally be inquisitive concerning the probable cost and the only possible answer is almost equally vague. If a member of the board of trustees is an engineer or if he has an engineering friend who is interested in the welfare of unfortunate children and can be drafted into service and if such a person is willing to spend considerable time, thought and energy on the project, the problem is greatly simplified.

Mechanical Problems Simplified

If the hospital boasts a good shop, capable of handling most of its repair work and mechanical alterations, it is much further simplified and the cost of the conversion may prove trifling. St. Luke's Hospital has three engineers on its board of trustees at the present time and mechanical problems are never a particularly serious consideration.

If, however, a commercial machine shop is resorted to for the conversion of the machine, it may have to be mechanically engineered, put on the drafting table, blueprinted and sent to the mechanics in the shop. Such a procedure may well run into several hundred dollars.

It is not the intent of this discussion to dictate methods or impose specifications that must be followed in making the conversions described but only to indicate what has been done and what may be done along similar lines.

"Yankee ingenuity" being what it is, it seems probable that interested individuals who are searching for answers to the problems of crippled children will devise ways and means superior to those that have been set forth.

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Shop Talk With a Moral

The Sad Tale of the Silver Fox

Everything happens to the housekeeping department. Any time executive housekeepers get together, say during the social hour after a local N.E.H.A. meeting, the stories of those little incidents that enliven a housekeeper's day, and add to her gray hairs, fly thick and fast, each one more fantastic than the last and each well calculated to prove that truth is stranger than fiction—and usually funnier.

For instance: There was the housekeeper at one of the swankier midwestern hotels who chortled quietly to herself while she listened to the head of the laundry department relate his latest cause for sorrow. It seemed that the washing machine had become clogged during the morning and investigation disclosed that the source of the trouble was a silver fox scarf that had somehow found its way into the washer, where no silver fox had any business to be.

It had been a fine scarf once, but after its sojourn in the washing machine the animal looked decidedly dispirited, what with a large hole in its back and the tail torn off. The tail, when it was finally retrieved, looked like a bedraggled caterpillar. What most surprised the laundryman, though, was that no one had reported a silver fox to be missing. So there it lay in the laundry waiting for someone to claim it.

Listening to the story, the housekeeper reflected that it was a nice change to hear about somebody else's troubles—she thought.

Later in the day, the executive chanced across one of the permanent guests of the hotel, who buttonholed her and inquired brightly: "Oh, Mrs. C., did Rose remember to send my fox scarf to be cleaned?"

It was then that a horrible suspicion crept into Mrs. C.'s mind. It just wasn't possible, but anyway she had better look into the matter. Somewhat glassy-eyed, she murmured soothingly to the guest and departed in search of Rose, the floor housekeeper. When questioned, Rose agreed that she had indeed been instructed to send the fur to be cleaned and that she had left it on a chair in the guest's apartment for the cleaner to pick up. Further, Rose added with conscious pride, she had not left the beautiful scarf out unprotected to collect dust. She had wrapped it in a sheet.

That was all the executive housekeeper needed to know. In spite of rigid instructions that all linen taken from the rooms must be examined to prevent just such accidents as this, the maid on the floor had simply scooped up sheet and fox with the rest of the soiled linen and tossed it down the laundry chute.

It isn't likely that a silver fox scarf will turn up in a hospital washing machine, but unless the linen is checked carefully before it goes to the laundry, almost everything else might—from the patients' personal effects to medicine bottles, thermometers and expensive instruments. And most of them are guaranteed to ruin irreplaceable linen.

There Is a Place for Everything

There is a lesson to be learned from this story, too: You have to think of everything when placing furniture in a room or ward. The executive housekeeper of a Chicago hospital happened to glance into the children's ward one gloomy afternoon and noticed that a light that should have been burning wasn't. As she entered the room, she found out why.

Beneath that particular light a tall chest had been placed, and on top of the chest the housekeeper beheld a small patient—not more than 3 or 4 years old. Becoming restless, the enterprising youngster had crawled up the side of his crib and, balancing himself on the rail, had managed to climb onto the chest.

Being of an exploratory turn of mind, the child had unscrewed the bulb, laid it gently on the top of the chest and was just in the act of poking an inquiring finger into the light socket when the housekeeper hurled herself across the room and snatched him out of harm's way, while he howled with rage and frustration.

The chest was moved immediately to a safer spot, away from the children's beds and well away from any electrical outlet.

HEADLINE NEWS

New England Assembly Hears Carter Discuss Rising Cost of Hospital Care

Who will pay the steadily rising cost of hospital service? This question was placed squarely before members of the New England Hospital Assembly in session March 11 to 13 in Boston, by Dr. Fred G. Carter, superintendent, St. Luke's Hospital, Cleveland. The average hospital bill of today in Cleveland is about 40 per cent higher than in 1940, Doctor Carter pointed out. At St. Luke's, for example, salary costs alone in 1945 were about equal to the total costs of operation in 1940. A forty hour week for hospital personnel would be a factor in further increased costs of hospital operation. "If the present trend continues for the next five years," warned Doctor Carter, "we may expect that the prewar bill of $6 to $7 will have advanced to $12 to $13 per day in 1950."

If our hospitals follow traditional evolutionary trends rather than totalitarian precepts in the future they must look to three main sources for payment for the services they render. These are: the patients themselves, in decreasing numbers; governments, national, state and local, and Blue Cross plans. "The ranks of the regular pay patients are thinning rapidly," he explained. "It should be obvious that hospitals, whether they like it or not, are finding increasingly large proportions of their bills being handled on the basis of group contracts.

"Voluntary insurance plans including those of insurance companies, as well as those of Blue Cross groups, probably are paying the hospital bills of from 30,000,000 to 40,000,000 of our people currently and this group will continue to grow at the expense of the so-called 'regular pay patient group.' If these plans are to serve and expand as we hope they will, they must expect to pay hospitals their complete costs for the care of their clients.

"With the absorption of private philanthropy by governments through higher taxes, it seems only fair that government should assume the burden which private philanthropy has carried for generations in the hospital field. This means that governments must accept the responsibility for the care of the indigent and the medically indigent at rates representing nothing less than complete costs. It does not mean that governments must accept a responsibilty of this nature for everybody. If it is admitted that the medical needs of the vast ma-

(*Continued on Page* 150.)

NEW ENGLAND HOSPITAL ASSEMBLY OFFICERS
Standing, left to right: Dr. Albert Engelbach; Dr. Francis J. Bean; Lester Richwagen; Paul J. Spencer; Howard Pfirman and Carl A. Lindblad. Seated, left to right: Donald S. Smith; Anne C. McDougal; Pearl R. Fisher, R.N.; Rev. Donald A. McGowan.

Surplus Hospital Items Advertised for Sale April 11 to May 3

WASHINGTON, D. C.—Certain items announced by War Assets Administration to go on sale April 11 through May 3 are available to hospitals and other priority groups. The items advertised are brand new and in excellent condition. Eligible hospitals may order on a 60 day credit basis. Inquiries and orders together with shipping instructions should be directed to the Medical-Surgical Section of the regional office.

The items listed for sale are:

1806 Bradford frames; original cost to government $30,250, selling for $16.75 each, less 40 per cent to priority claimants.

3128 double immersion bowl stands complete with bowls; original cost to government $123,556, selling for $10 each, less 40 per cent (these units were $39.50 each; not less than three units may be purchased).

1828 portable electric therapeutic bakers, Victory type in white enamel, original cost to government, $27,420, selling for $15 each, less 40 per cent; minimum sale, four.

126,799 rubber bags or ice caps; 2920 hot water bottles; 46,763 douche bags. The total cost of the last group of items to the government was $67,072.63.

Mental Health Bill Passed by House; Senate Hearings Start

WASHINGTON, D. C.—The National Mental Health Bill, providing $4,500,000 for a psychiatric research center at Bethesda, Md., and annual appropriations up to $10,000,000 to stimulate research and aid in training adequate personnel for state and local hospitals, was passed by the House of Representatives March 15.

On March 6, the first day of hearings on the bill in the Senate, Dr. Thomas Parran told a Senate subcommittee that research in mental illness has lagged far behind research in other fields of medical science.

Brig. Gen. William Menninger, head of the Menninger Clinic, Topeka, Kan., and now director of the neuropsychiatry division, Office of the Army Surgeon General, said that during the war there were more than 1,000,000 admissions to Army hospitals for neuropsychiatric ailments.

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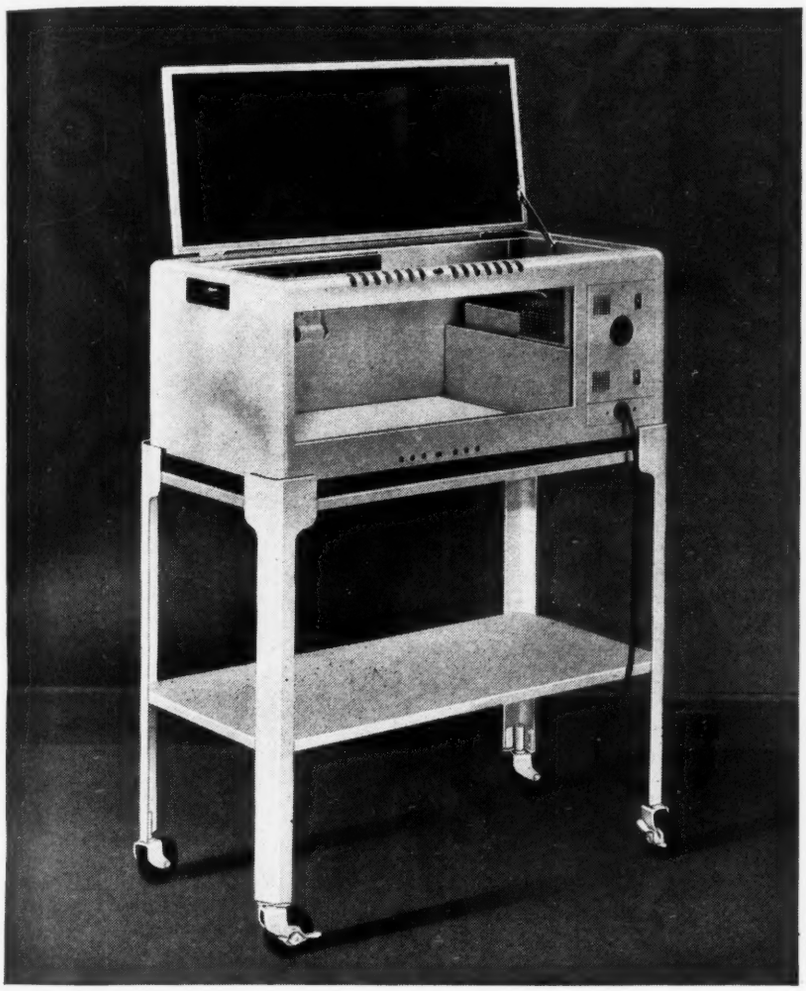

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Parran, Smelzer, Fleming Testify at Hospital Construction Bill Hearings

By EVA ADAMS CROSS

WASHINGTON, D. C.—The need for a national hospital construction program in which the states are assisted by the federal government was emphasized by Dr. Thomas A. Parran and others through five days of hearings, beginning March 7, on S.191, the Hospital Survey and Construction Bill. Testimony was given before the public health subcommittee of the House Committee on Interstate and Foreign Commerce. S.191 was passed by the Senate December 11.

In order for the nation to have good health and medical care, said Doctor Parran, it is necessary to provide the workshops of medicine, that is hospitals and health centers, with modern equipment distributed geographically throughout the country in proportion to need. He gave in his testimony the over-all needs of the country for hospitals and health centers; the progress the states have already made in developing surveys and plans for an integrated system of hospitals and health centers, and amendments which he considered would improve the bill under discussion.

Surgeon General Parran called attention to the fact that the problems encompassed by S.191 are already under active consideration by official bodies of one kind or another in nearly all the states and territories. Numerous statewide surveys are now in progress to determine health facility needs. Intensive surveys under official auspices either are in progress or are being planned in all but 12 of the 48 states and four territories, he said. Fifteen states in 1945 enacted legislation authorizing statewide surveys of hospital and health center facilities and the planning of statewide construction programs.

Among amendments to S.191 which Doctor Parran recommended was that of increasing the limits of authorized annual appropriations and of extending the program optionally beyond a five year period. The original bill authorized $100,000,000 for the first year with no ceilings for nine years to follow. The Senate-approved S.191 of December 11 authorized $75,000,000 for each of five years. Doctor Parran recommended $75,000,000 for the first year and no ceiling for the remaining nine years. As a second choice, he suggested $75,000,000 for the first year and $100,000,000 for the remaining nine years.

Another recommendation of the surgeon general was that office space for physicians be included in the health facilities built with funds authorized by this legislation. He pointed out the fact that 50,000 doctors and dentists have been released from the Army and Navy. Unless a doctor can establish or reestablish his office, he cannot practice his profession.

Dr. Donald C. Smelzer, immediate past president of the American Hospital Association, declared in his testimony that the A.H.A. gave its active support to the legislation in the form in which it passed the Senate. The American Hospital Association, he said, was in a position to realize the urgent necessity for providing additional hospitals and related facilities and making them more widely available. He placed the association on record as being in opposition to the amendments which have been suggested as embodied in H.R. 5628 (the Priest bill introduced February 28).

Maj. Gen. Philip Fleming, Federal Works Administrator, testifying at Mr. Priest's request, endorsed S.191's objectives. He objected, however, to channeling funds through states to localities and advocated direct dealing between the federal government and local applicants. He recommended complete control by the federal government (rather than state control) of construction and struck at duplication of activities, urging that the United States Public Health Service, expert on professional health matters, should be given the medical aspects of the bill to administer while the Federal Works Agency handled construction activities.

Braceland Honored by Navy

WASHINGTON, D. C.— Capt. Francis J. Braceland, M. C., USNR, has been awarded the Legion of Merit for services as Special Assistant in Psychiatry to the Surgeon General of the Navy and Chief of the Neuropsychiatry Branch of the Bureau of Medicine and Surgery. Captain Braceland was dean of the school of medicine and professor of psychiatry at Loyola University, Chicago, prior to entering upon active duty in the Navy in January 1942.

V.A. Seeks Hospital Aids

WASHINGTON, D. C.— The Veterans Administration is seeking the services of 1500 trained personnel to carry forward its rehabilitation program in all veterans' hospitals, it was announced March 19. Particularly wanted are former service men and women who were trained in convalescent and reconditioning programs. Salaries are said to range from $2100 to $7175 annually.

Twenty-Four Hour Medical Service Ordered for Veterans

WASHINGTON, D. C. — Veterans Administration hospitals were ordered March 10 by the Chief Medical Director, Dr. Paul R. Hawley, to maintain twenty-four hour medical service for veterans. In small regional offices where continuous duty would be a hardship to the few doctors assigned, a clerk could receive telephone calls but a responsible medical officer must be "on call," Doctor Hawley said.

Other instructions from the chief medical director included the following:

1. Neglect of patients will be considered an "unforgiveable sin."
2. Overtime pay will not be paid to doctors, dentists or nurses in the Department of Medicine and Surgery who are not in Civil Service.
3. Requirements of patients will govern hours of duty for doctors.

Neglect of patients, wrote Doctor Hawley in an outline of Veterans Administration policies to each medical director of the 13 branches, will not be tolerated under any circumstances. Patients will be seen promptly on admission and as often thereafter as their condition requires, he directed.

Announce Examinations for Appointment to Navy Medical Corps

WASHINGTON, D. C.—Professional and physical examinations for the U. S. Navy Medical Corps, will be conducted at 29 naval hospitals May 6 to 10. Successful candidates will be appointed as assistant surgeon and acting assistant surgeon with the rank of lieutenant, junior grade.

Eligible to take the examinations are medical officers of the Naval Reserve who have served on active duty less than six months in commissioned rank. These officers were those deferred from active duty under the 9-9-9 program. Civilian doctors having no affiliation with the Navy are also eligible.

Third and fourth year medical students may take the tests for appointment as acting assistant surgeon, successful completion of which would qualify them for internships in naval hospitals. Third year students, however, must have completed three years' medical training to be eligible. Candidates for assistant surgeon must be graduates of approved medical schools who have completed intern training in a civilian or naval hospital or who will complete such training within four months of the date of the examinations.

Civilian Requests for Streptomycin Must Be Made to Keefer, C.P.A. Asserts

By EVA ADAMS CROSS

WASHINGTON, D. C.—Allocations of streptomycin under the recently issued Schedule 119 of Order M-300 became effective March 1. Approximately 63 per cent of the available supply is being allocated to the Army, Navy, U. S. Public Health Service and the Veterans Administration, according to the Civilian Production Administration. C.P.A. stated that civilian requests for streptomycin must be made of Dr. Chester S. Keefer at his headquarters in the Evans Memorial Hospital, Boston, after March 1.

It was further stated that there will be no commercial distribution of the drug at this time. The Civilian Production Administration and the producers will not supply material directly for civilian appeals. Physicians were cautioned to restrict their appeals to Doctor Keefer for streptomycin to infections that are not susceptible to the action of the sulfonamides, penicillin and other therapeutic agents.

Grants-in-aid for clinical study of streptomycin amounting to more than $500,000, contributed in equal shares to the National Research Council by 11 pharmaceutical manufacturers, were recently announced by the Chemical Division of C.P.A. The manufacturers making the contributions constitute the streptomycin producers' advisory committee of C.P.A. The grants-in-aid are to finance a program for the clinical evaluation of streptomycin in infectious diseases by the committee on chemotherapeutics and other agents of the National Research Council. Doctor Keefer, who headed the clinical investigation of penicillin for O.S.R.D. during the war, will have charge of the new program.

Streptomycin production has increased from approximately 3000 grams last September to approximately 27,000 grams in March of this year. Later this year, it is anticipated, manufacturers will be producing the drug at a greatly increased rate. It is expected that streptomycin will prove a valuable supplement to penicillin in that it promises to be effective against a number of infectious diseases that do not yield to treatment with penicillin.

The donors of the $500,000 for the grants-in-aid are: Abbott Laboratories, North Chicago, Ill.; Commercial Solvents Corporation, New York City; Charles Pfizer and Company, Brooklyn, N. Y.; E. R. Squibb and Sons, New York City; Eli Lilly and Company, Indianapolis; Heyden Chemical Corporation, New York City; Merck and Company, Inc., Rahway, N. J.; Parke, Davis and Company, Detroit; Schenley Laboratories, Inc., New York City; Upjohn Company, Kalamazoo, Mich., and Wyeth Incorporated, Philadelphia.

British Health Bill Opposed by Members of Medical Group

Ownership and operation of all major hospitals would be turned over to the government under the health bill introduced into Britain's House of Commons late last month by Aneurin Bevan, minister of health. The bill, which met with immediate public opposition from the British Medical Association, would also provide complete health service for the entire population, with doctors paid a salary by the government.

Estimated cost of the proposed health plan would be in excess of $600,000,000 annually, to be provided out of tax funds and fees paid into the National Insurance Fund. For a fee amounting roughly to $15 per person per year, the benefits would include all needed hospitalization and medical care, including glasses, dentures, medicines, nursing and auxiliary services.

Doctors' salaries under the plan would be based on the number of patients cared for. Patients who wished to receive care outside the plan would be free to employ the doctors of their choice and pay them directly for such services. Doctors who chose to could remain entirely independent of the program, or they could join the plan and care for private patients in addition.

The proposed bill gives the health minister authority to acquire any existing hospitals needed to effect the program and to build hospitals, health centers and clinics.

Declaring that the majority of British physicians might refrain from cooperating in the plan if the proposed bill were passed, a spokesman for the B. M. A. was quoted as saying that the plan would make the doctor a "civil servant instead of the patient's friend and advocate."

Health Conference Called

WASHINGTON, D. C.—The forty-fourth annual conference of state and territorial health officers with the U. S. Public Health Service will be held April 8 to 11 in the Public Health Service Building in Washington, D.C.

V.A. Will Pay Bills for Emergency Care, Hospitals Assured

Hospitals may furnish emergency care, including out-patient care, to veterans with assurance that the Veterans Administration will pay the necessary bills even though specific authorization has not been given in advance, Lt. Col. Harry E. Brown, acting director of the V.A.'s Medical Administration Service, told THE MODERN HOSPITAL in reply to an inquiry. V.A. Circular No. 26 specifies that payments to hospitals for such care will be made pending adjudication of claims, so the hospital incurs no risk of financial loss in accepting these cases.

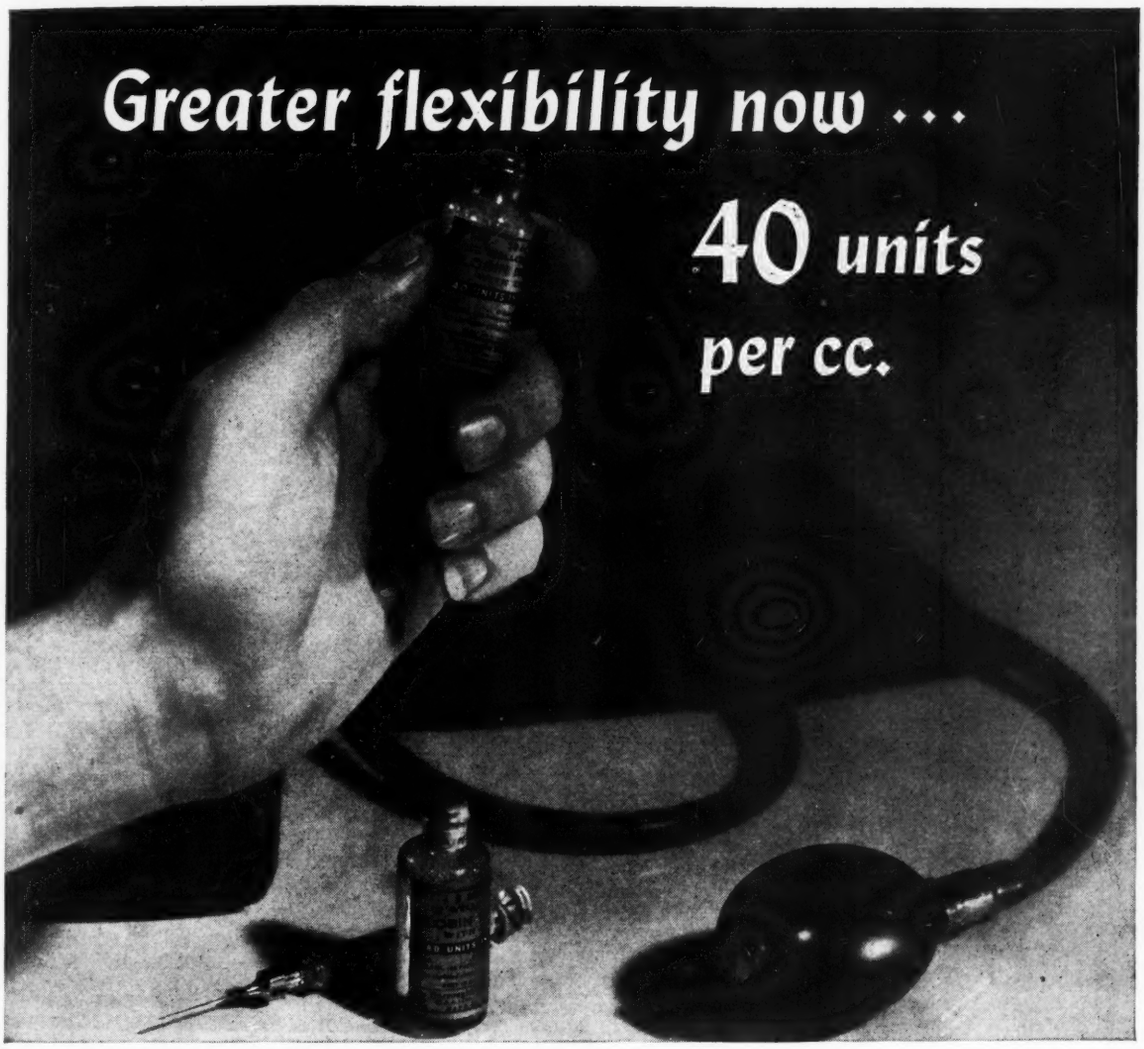
"In order to eliminate any delay in rendering out-patient treatment or emergent hospitalization in private or contract hospitals," the circular states, "pending adjudication for claims or pension, and in order to render full service to disabled veterans, authority is hereby granted to furnish out-patient treatment to veterans at the expense of V.A. independent of whether the need for out-patient treatment is emergent or not on a basis of a determination of *prima facie* eligibility. Hospitalization in a private or contract hospital may also be authorized under the conditions outlined above in an emergency."

Hawley Leaves Army for V.A.

WASHINGTON, D. C.—Maj. Gen. Paul R. Hawley retired from the Army to accept appointment March 3 as chief medical director of the Department of Medicine and Surgery, Veterans Administration. Since last August, General Hawley has been on loan from the Army as acting chief medical director. His retirement closes a career of more than twenty-nine years with the Army Medical Corps. He was chief surgeon for the European Theater of Operations in World War II when Gen. Omar Bradley was on duty there.

Science Bill in Committee

WASHINGTON, D. C.—The revised bill, S.1850, on the National Science Foundation, is still before the Senate Military Affairs Committee. Introduced February 21 by Senator Kilgore for himself and Senators Magnuson, Johnson, Pepper, Fulbright, Saltonstall, Thomas and Ferguson, the bill is a revised and amended edition of earlier bills introduced by these same senators. It has since been reported favorably by the Senate Subcommittee on War Mobilization.



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Blue Cross Directors Discuss Methods of Payment to Hospitals

Methods and amounts paid to hospitals for service to Blue Cross subscribers were the major topics for discussion at the semiannual conference of Blue Cross plans in Cincinnati March 25-27. Various methods based on costs, hospital billings and flat rates were presented and analyzed, and George Bugbee, executive director of the American Hospital Association, urged plan executives to approach the problem of payments with better understanding of the many pressures with which hospitals are faced.

The conference passed a resolution reaffirming the service benefit principle and authorizing the Blue Cross commission to work out with the board of trustees of the A.H.A. a program of effecting compliance on the part of plans with A.H.A. approval standards, including the provision of benefits on a service, as opposed to a cash allowance, basis. The resolution also requested joint action by the commission and the A.H.A. to "establish an equitable method or methods for reimbursing hospitals which provide service benefits to Blue Cross members."

Another conference resolution approved an increase in plan payments to support the commission's national office, including the recently established national enrollment office, whose activities the plan directors heartily endorsed.

A representative of the Veterans Administration discussed the V.A.'s program for providing hospital care in civilian hospitals under arrangements similar to those recently completed in Michigan, where Blue Cross acts as an agent for the hospitals. It should be made clear to hospitals, the V.A. spokesman explained, that contracts with hospitals calling for care of veterans do not require a certain number of beds to be set aside for veterans; rather, the hospital agrees only to admit veterans needing care as expeditiously as possible and to accept payment at the agreed rates. To protect hospitals in this period of rising costs, it was added, provision was made for adjustment of rates on the basis of new cost statements submitted at six month intervals.

In a meeting open to the public and attended by representatives of the Cincinnati plan's subscriber groups, Roy McDonald, publisher of the *Chattanooga Free Press,* and Louis Seltzer, editor of the *Cleveland Press,* characterized Blue Cross as a public service and emphasized that its strength developed from its hospital-community sponsorship. John W. Bricker, former governor of Ohio, addressed the conference banquet on "Voluntary Activity and the People's Health," emphasizing that prepayment programs aimed at improving the national health

must have voluntary motivation as opposed to tax support on a compulsory basis.

Thomas A. Hendricks, secretary of the American Medical Association's Council on Medical Service and Public Relations, reported on the A.M.A.'s newly created division of medical prepayment plans. The A.M.A. had established standards of approval for medical plans, he said, and was working actively to make certain that an integrated, nationwide system of medical plans was being developed under state medical society sponsorship.

Next to hospital payments and hospital relations generally, the most important problems Blue Cross has today are in the field of inter-plan relations, C. Rufus Rorem, director of the commission staff, told the conference. A new procedure covering inter-plan membership transfers was adopted by the conference on recommendation of the commission staff and Leon R. Wheeler of Wisconsin, chairman of the committee on administrative practice.

Other commission and committee reports were presented by John Mannix of Chicago, commission chairman; Reginald Cahalane of Boston, public education committee; Harold Lichty of Detroit, enrollment committee; J. Douglas Colman of Baltimore, government relations, and E. D. Millican of Montreal, Canadian development.

W.A.C. Announces Sale of Surplus Food and Agricultural Items

WASHINGTON, D. C. — Surplus food and agricultural products may now be purchased at a 40 per cent discount from "fair value," by eligible nonprofit institutions, according to an announcement March 6 of the War Assets Corporation. Up to now, under an interim procedure, food and agricultural commodities were not included in the discount program. Public health and private nonprofit welfare institutions will route their requests through the public health specialist located in the War Assets Corporation regional office serving their locality.

Digests of offerings will be mailed at regular intervals to field representatives of Public Health Service. Offerings will be released periodically as food and commodities are available for sale. The general impression in Washington is that there will be an extremely limited variety of surplus food and commodities available through the Department of Agriculture.

In addition to normal food items, the Department of Agriculture is acting as the disposal agency for several non-food items which are useful in the medical field. Among such items are: vitamins and vitamin preparations, including cod liver and other vitamin-bearing oils, fats and fat derivatives, such as wool fat and lard; certain oils, such as castor and linseed; glycerin; turpentine; certain gums and balsams; yeast products, and certain sugars, such as lactose.

F.W.A. Advances Funds for Hospitals

WASHINGTON, D. C. — Montgomery, Ala., was advanced $56,000 March 1 by the Federal Works Agency to finance the preparation of plans and specifications for a 250 bed general hospital estimated to cost $1,511,000. A federal advance of $10,940 was made to Gainesville, Ga., for the preparation of plans for a 200 bed general hospital there. The new hospital will have beds and training facilities for 50 nurses. The estimated cost of the project is $1,680,500.

Advances were also made by F.W.A. for planning smaller hospitals in the South. The George County Board of Supervisors received an advance for plans and specifications for a 30 bed general hospital and nurses' dormitory at Lucedale, Miss. The estimated cost of the hospital is $115,386, the federal advance is $3618.

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Surplus Medical and Hospital Items Offered to Priority Claimants Exclusively

By EVA ADAMS CROSS

WASHINGTON, D. C.—More than 850,000 medical and hospital items are being offered to priority claimants exclusively, according to an announcement March 7 of the War Assets Corporation. These items are a part of a nationwide sales program which includes almost $9,000,000 worth of medical and surgical surplus to be sold in all disposal regions during the next few months. Hospitals, health and welfare institutions certified by the Federal Security Agency will be allowed a discount of 40 per cent below the fair value which has been established for these items. W.A.C. field offices are supposed to give eligible priority claimants due notification of such sales.

Included in the list are the following:

Back rests made with a link fabric spring and strong angle iron frame; 796 units valued at $1114.

Operating and examining tables of metal construction with white enamel finish; 641 units valued at $48,076.

Holders for clinical record charts; 89,598 units valued at $31,359.

Cone shaped transparent flint glass medicine glasses; 761,712 units valued at $22,851.

Food carts, consisting of cart, tray, two food compartments and plastic wheels, two of which are swivel, with handle in the rear; 71 units valued at $5990.

Knockdown dressing carts or carriages of conventional design, with tubular framework on wheels, supporting two steel shelves with rubber-tired spoke wheels, two of which are swivel; 1655 units valued at $17,791.

Some of these sales embrace sufficient quantities to permit offerings through commercial channels. A case in point was that of 75,000,000 bottles of insect repellent which were made available in March to purchasers throughout the nation after priority claimants had had fifteen days for purchasing what they wanted. Other sales included $40,000 worth of surgeons' gloves; $48,000 worth of operating knives, handles and blades; 150,000,000 sputum cups.

Of special interest to hospitals and emergency clinics was the announcement of a sale of electric blood refrigerators. The Medical and Surgical Division of the W.A.C. regional offices has prepared sales programs for relatively scarce hospital equipment. Hospital officials should watch for the early release of operating lamps, immersion stands and bowls, bone plates, surgical screws, screw drivers, sponges, forceps and dressings.

Nonprofit institutions organized primarily for health purposes or research and eligible to purchase at a discount should send their orders in quadruplicate directly to the U. S. Public Health Service specialist in the W.A.C. regional office, consumer goods division, located in their area. Orders should be accompanied by an application (in duplicate) requesting the discount and certifying that the institution will use the material to promote public health or sanitation, that the property is required to fill a legitimate need and that it will not be resold for three years without the written consent of the disposal agency.

Study Amputation Technics

WASHINGTON, D. C.—A commission on prosthetic devices, comprised of five Army and civilian experts, is en route to Europe to make a study of technics in amputation surgery, developments in the field of prosthetics and artificial limbs and the rehabilitation and reconditioning of amputees, the Office of the Surgeon General revealed March 18. Making the trip at the suggestion of the Secretary of War, the commission plans to visit scientific centers in England, France, Switzerland, Germany, Sweden and possibly Russia.

List Differences in S.191 and Priest Hospital Construction Bill

By EVA ADAMS CROSS

WASHINGTON, D. C. — Mr. Priest on February 28 introduced H.R. 5628, a bill that would authorize grants to the states for surveying their hospitals and public health centers and for planning construction of additional facilities, and would also authorize grants to assist in construction. It is similar to S.191 but is not a companion bill.

The differences in the two bills are as follows: Under S.191, the surgeon general prescribes general regulations governing state construction plans with the *approval* of the Federal Hospital Council and the Federal Security Administrator. Under H.R. 5628, he prescribes such regulations *after consultation* with the council. The Priest Bill also changes the functions of the council in hearings on disapproved plans. The council does not, as under S.191, make the final determination; this becomes the prerogative of the Federal Security Administrator. In other words, the council will have no veto powers under the Priest Bill.

Under S.191 five of the eight council members would represent the professional hospital and health fields and three, the consumers of hospital services. Under the new bill, four of the eight would be professional and technical representatives and four, consumer representatives.

H.R. 5628 includes two requirements never embodied in S.191: The surgeon general must include in his annual report to Congress (a) a full report of the administration of this program, including data on appropriations and disbursements; a record of consultations with the Federal Hospital Council; recommendations and determinations of the Council and comments thereon, and (b) after consultation with the Federal Hospital Council, recommendations as to legislation to carry out the purposes of the title. Similar requirements were included in S.1050 and its House companion bill—the Wagner, Murray, Din-

bill as passed by the Senate, have been

The provisions for appeal to the courts which were incorporated in S.191, prior to being reported out by the Senate Committee, and which were part of the bill as passed by the Senate have been eliminated entirely by H.R. 5628.

H.R. 5628 incorporates amendments similar to those which Senators Wagner and Murray proposed while S.191 was under discussion on the Senate floor. It requires federal standards for maintenance and operation, as well as for construction and equipment. It not only requires, as does S.191, that the state plan include minimum standards for the maintenance and operation of hospitals benefiting under this program, but requires that state minimum standards conform with the federal standards. H.R. 5628, in addition, requires federal standards to "assure that hospitals under this act are available to all practitioners in the community who are licensed in the state in accordance with provisions necessary to safeguard the quality of hospital services."

H.R. 5628 requires the surgeon general to include in his general regulations the ratio of public health centers needed throughout a state for adequate services. It permits a ceiling ratio of one per 20,000 population.

Buys Tennessee Hospital

Kingston Pike Hospital, Inc., at Knoxville, Tenn., has purchased the Howard-Henderson Hospital in that city, C. C. Burkhart, superintendent of Kingston Pike, has announced. Officers are president, Dr. Park Niceley; vice president, Dr. George Kelley; secretary-treasurer, Dr. Roy Fisher Jr., and superintendent, C. C. Burkhart.

Russell Nye Named President-Elect of Texas Hospital Group

Tol Terrell, administrator, Harris Memorial Hospital at Fort Worth, took office as president of the Texas Hospital Association at the annual meeting in Fort Worth March 21 to 23. Terrell succeeded Lawrence R. Payne of Baylor University, Dallas. Russell Nye, administrator of the City-County Hospital at Fort Worth, was named president-elect.

More than 700 hospital administrators, department heads, trustees and auxiliary members attended the sessions, which included discussions of personnel policies and practices, nursing services, veterans' care, Blue Cross, hospital accounting and national legislation affecting hospitals.

An especially interesting feature of the meeting was the attendance and participation of 52 delegates who were representatives of the women's auxiliary groups of Texas hospitals. Speaking for this group, Mrs. Theodore A. Binford of Corpus Christi, president of the state hospital association's auxiliary, stressed the importance of auxiliaries in educating the public on hospital and medical problems generally. Mrs. Binford said that attendance at the hospital meetings had helped auxiliary members to a better understanding of hospitals and would thus aid them in interpreting their hospitals to their respective communities.

James A. Hamilton of New Haven, hospital consultant and professor of hospital administration at Yale University, told hospitals they must "get their own house in order before the unions did it for them," from the standpoint of personnel practices. Higher salaries for hospital employes are not the whole answer, Hamilton said. In addition, hospitals must offer security for the future, give employes the sense of belonging to the institution and its work and provide competent, friendly supervision. "Be sure your personnel policies are clearly defined and stated," Hamilton declared. "Then be sure every employe understands them."

Hospitals should accept greater responsibility for selling Blue Cross, Everett W. Jones, vice president of The Modern Hospital Publishing Company, told the group. He urged hospitals to make certain that all employes, medical staff members and trustees are fully informed about Blue Cross and take advantage of every opportunity to extend public understanding and enrollment. Jones also told a session on purchasing problems that hospitals must plan from six months to a year ahead for purchases of mechanical, building and professional equipment and that needs for linens, chinaware, silver and other institutional supplies must also be analyzed far in advance.

Nursing problems in Texas were discussed by Marjorie Bartholf of John Sealy Hospital at Galveston; Marie Luppold of Methodist Hospital, Houston; Lucy Harris of Harris Memorial Hospital, Fort Worth; Zora M. Fiedler, Baylor University, Dallas, and Sister Charles Marie, Incarnate Word College, San Antonio. Following their presentation of various aspects of nursing service today, there was a round table discussion centered largely on the advisability of having both practical and professional nursing service in hospitals and of the nature and amount of training the practical nurse must have.

Norman B. Roberts, director of the hospital survey for Texas, reported on the progress and problems of the state survey program.

In addition to President-Elect Nye, officers elected for the coming year were: treasurer, Oswald Daughety, Hermann Hospital, Houston; first vice president, Mother M. Regina, Mother Francis Hospital, Tyler; second vice president, J. H. Felton, Lubbock General Hospital, Lubbock; third vice president, D. S. Riley, Malone and Hogan Clinic, Big Spring. (*Continued on Next Page.*)

Above: the exterior and an interior view of Emily Winship Woodruff Building, Crawford W. Long Memorial Hospital, Atlanta, Georgia. Hentz, Adler & Shutze, architects; Newcomb & Boyd, consulting engineers; Carrier Atlanta Corp., air conditioning contractors

In the Woodruff Building at Crawford W. Long Memorial Hospital, winter heating and summer cooling are provided for patients' rooms by individual air conditioning units. Other areas are heated and cooled by central air conditioning systems . . . There are 172 Johnson "Summer-Winter" thermostats, each of which is the automatic "brain" for one of the conditioning units, maintaining exactly the desired temperature in each room. In addition to Room-by-Room Control, Johnson year-'round automatic temperature regulation is applied also to five central conditioning systems which serve operating and observation rooms, nurseries, delivery rooms, X-ray suites, and cafeteria.

This example of JOHNSON Individual Room CONTROL is striking evidence of Johnson versatility—fitting the control apparatus to the job at hand, regardless of the type of heating or air conditioning equipment. Long ago, hospital administrators turned to Johnson Control to satisfy the "24-hour call" for varied temperatures in many different rooms and departments.

The adaptability of Johnson automatic temperature control systems, made possible by Johnson engineers and installation mechanics in principal cities, is one reason why Johnson is called upon time and again by the same people to solve their next problem. Ask your heating and air conditioning engineer or contractor—or call a Johnson engineer from a nearby branch office. JOHNSON SERVICE COMPANY, Milwaukee 2, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON *Automatic Temperature and Air Conditioning* **CONTROL**

DESIGN • MANUFACTURE • INSTALLATION • SERVICE

New trustees elected were: W. D. Bohman, John Sealy Hospital, Galveston, and George Buis, Brackenridge Hospital, Austin. Delegates to the American Hospital Association are Mrs. Josie M. Roberts of the Methodist Hospital, Houston, and Russell Nye, president-elect of the association. Eva M. Wallace, All Saints Hospital, Fort Worth, and Julian H. Pace, Hillcrest Memorial Hospital, Waco, were named as alternates.

A.S.T. Program to End June 1

WASHINGTON, D. C. — The Medical Army Specialized Training Program will be terminated by the first of June this year. Enlisted men assigned to A.S.T.P. for medical training who are scheduled to be graduated from medical school before July 1, will not be separated from the Army regardless of age, length of service, critical score, or by virtue of having three or more children under eighteen years of age. They may be separated only because of undue hardship or because of importance to national health, safety or interest.

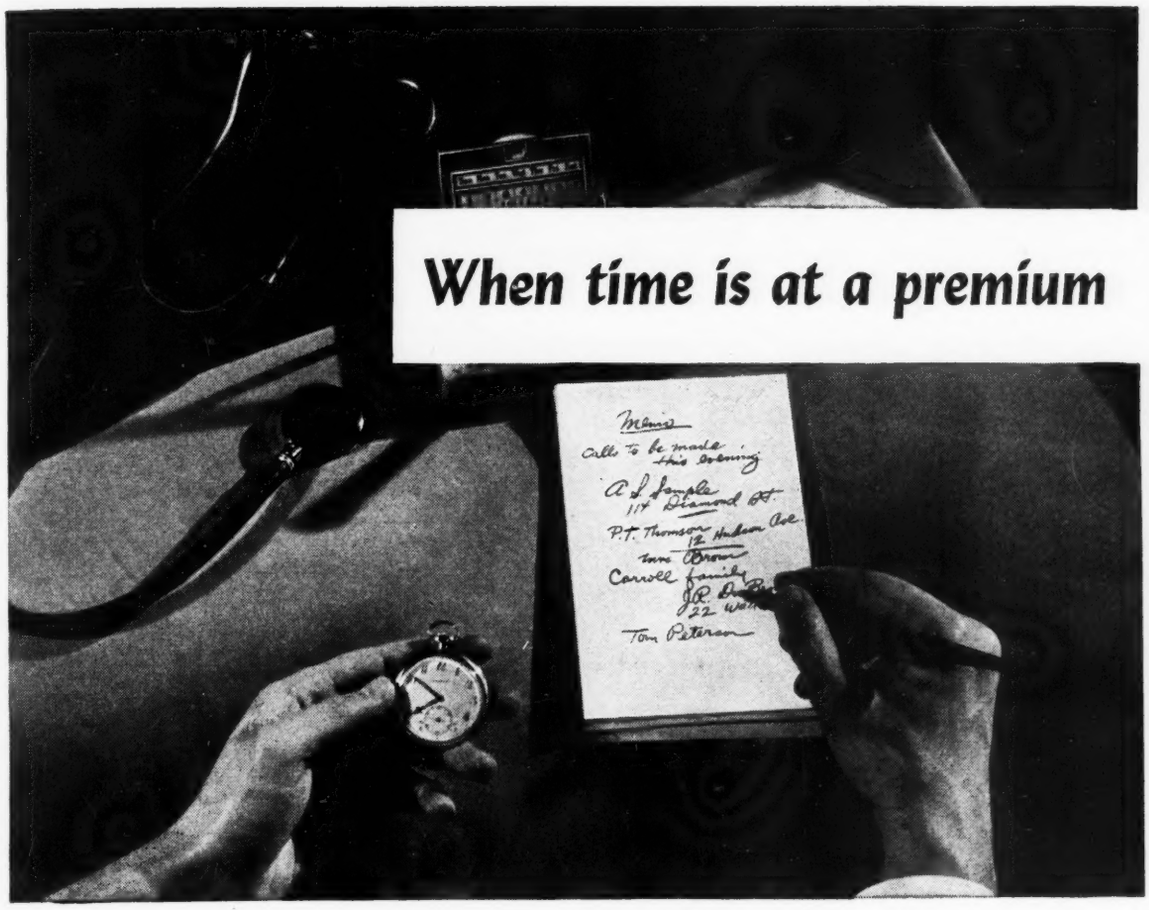
Enlisted men not scheduled to be graduated from medical school prior to July 1 may be discharged if they meet current War Department criteria for separation.

Enlisted men, not eligible for separation, who signify their intention to continue their medical studies and are acceptable at an accredited medical school, will be released from active federal service and transferred to the Enlisted Reserve Corps.

Reveal Estimates of Funds to be Allocated Under S.191

Accompanying Dr. Thomas Parran's testimony on S.191 before the House subcommittee on public health (see page 134) were the following estimates of funds that would be allocated to and spent by the several states under the proposed legislation:

State	*Federal Allotment (100 per cent population weighted by federal percentage squared)*	*Matching State Allotment*
Totals	$75,000,000	$64,168,905
Alabama	2,920,275	1,181,812
Alaska	38,250	38,250
Arizona	447,825	316,773
Arkansas	1,991,700	697,969
California	1,986,825	3,974,246
Colorado	671,400	583,553
Connecticut	403,575	807,271
Delaware	75,075	133,641
District of Columbia	268,500	444,647
Florida	1,673,475	1,172,570
Georgia	3,135,525	1,410,692
Hawaii	226,125	226,125
Idaho	313,800	270,231
Illinois	2,732,550	3,839,238
Indiana	1,629,900	1,746,032
Iowa	1,324,875	1,154,772
Kansas	989,400	905,276
Kentucky	2,689,725	1,113,619
Louisiana	2,276,025	1,158,966
Maine	436,575	405,097
Maryland	763,125	1,059,046
Massachusetts	1,463,100	2,065,843
Michigan	1,882,650	2,689,108
Minnesota	1,634,550	1,261,021
Mississippi	2,502,600	834,199
Missouri	2,299,200	1,808,714
Montana	236,250	237,672
Nebraska	730,650	615,922
Nevada	35,550	71,111
New Hampshire	336,900	224,319
New Jersey	1,184,400	1,992,638
New Mexico	491,250	239,886
New York	2,869,500	5,739,861
North Carolina	3,529,125	1,521,141
North Dakota	346,500	265,150
Ohio	2,458,875	3,403,966
Oklahoma	1,739,475	970,410
Oregon	400,050	596,587
Pennsylvania	4,336,350	4,718,465
Puerto Rico	2,307,300	769,099
Rhode Island	260,250	383,614
South Carolina	2,047,800	790,060
South Dakota	402,600	275,520
Tennessee	2,707,275	1,278,700
Texas	5,170,125	3,355,809
Utah	330,975	309,952
Vermont	207,000	155,776
Virginia	2,318,100	1,575,902
Washington	473,625	937,233
West Virginia	1,509,900	791,776
Wisconsin	1,642,800	1,518,862
Wyoming	150,750	130,763



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EASE AND CONVENIENCE OF ADMINISTRATION

Pyridium is convenient to administer. No laboratory control, accessory medication, or other special measures are necessary for effective Pyridium therapy.

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Therapeutic doses of Pyridium may be administered with complete safety throughout the course of cystitis, pyelonephritis, prostatitis, and urethritis.

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Prompt, *gratifying* relief of distressing urinary symptoms is the characteristic response to Pyridium therapy.

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For gratifying relief of distressing symptoms in urogenital infections.

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MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

Carter Discusses Costs at New England Assembly

(*Continued From Page* 132)

jority of our people are well taken care of and that our concern should be for the low-income and non-income groups, then legislation should focus on these groups and not on the entire population."

Large and enthusiastic audiences heard Doctor Carter and other prominent authorities and participated in the special sessions held each afternoon on such subjects as public relations, trustees, volunteers, credits and collections, purchasing, personnel, dietetics and accounting. In many instances the halls assigned to these conferences were inadequate to accommodate the crowds and larger facilities had to be provided.

Group practice and changing professional relationships were considered in general session by Dr. Frederick T. Hill, medical director, Thayer Hospital, Waterville, Maine; Donald S. Smith, superintendent, Mary Hitchcock Memorial Hospital, Hanover, N. H., and Dr. Jean A. Curran, dean, Long Island College of Medicine, Brooklyn N. Y. That the term "group practice" is one of varied connotations is the unanimous opinion of these authorities. Unfortunately, too often it is thought of merely in terms of clinics or hospitals rather than from the standpoint of the entire community. At the same time much emphasis was placed upon its professional and economic advantages and the fact that the voluntary hospital forms the focal point for such endeavors.

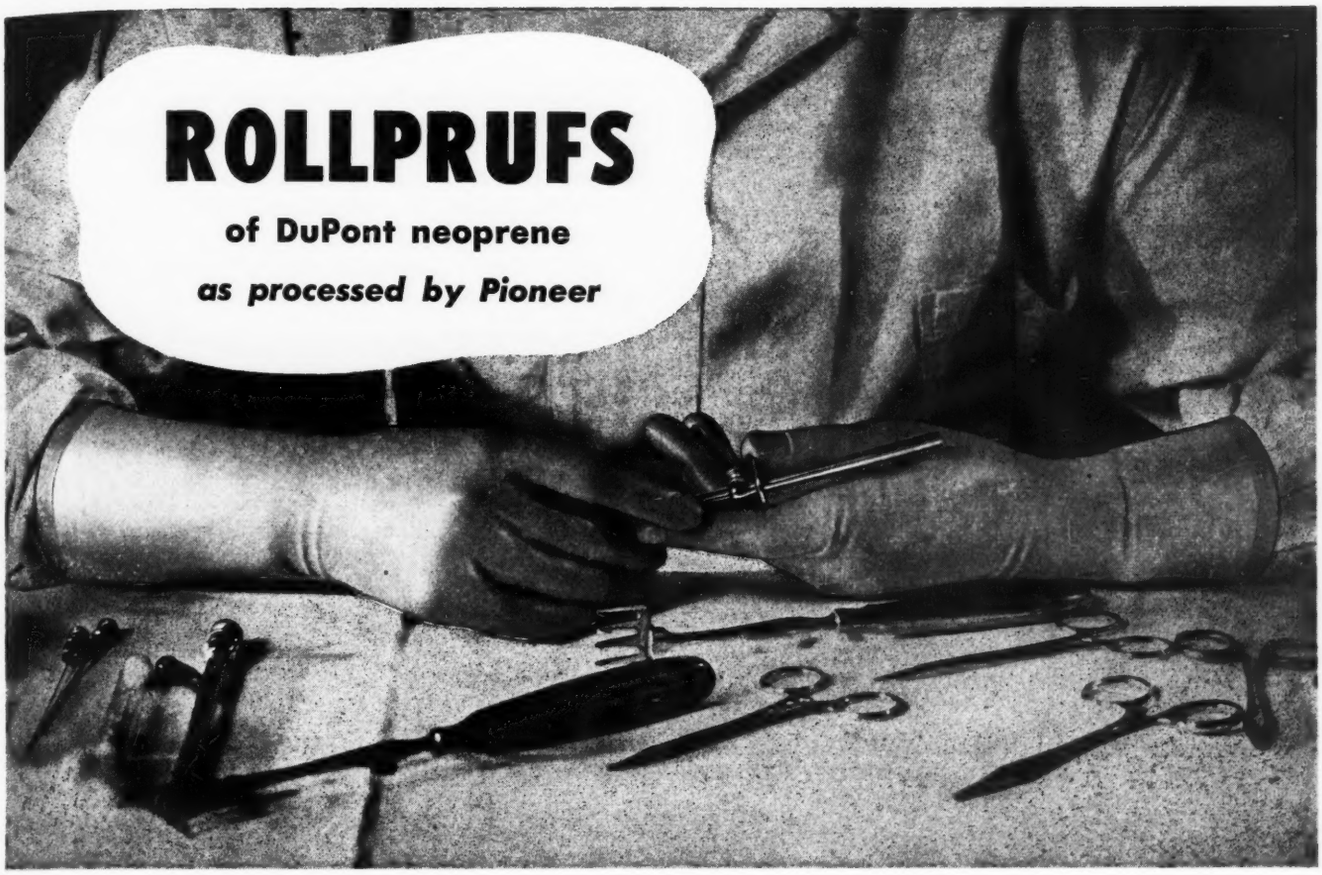
Speaking at the public meeting Maj. Gen. Paul R. Hawley, chief medical director of the Veterans Administration, indicated that an approaching shortage of government hospital facilities would mean the allocation of 25,000 veteran patients to private hospitals. Dr. Karl T. Compton, president, Massachusetts Institute of Technology, the guest speaker at the assembly's annual banquet, described the potentialities of the great store of atomic knowledge gained by scientists in the development of the atomic bomb and the new technics of scientific investigation which may open up a new era in medicine and probably form the most promising basis of the great cooperative attack on cancer.

Donald S. Smith becomes the new president of the assembly. Other officers for the new year are: vice president, Rev. Donald A. McGowan, director of Catholic Hospitals, archdiocese of Boston; treasurer, Lester E. Richwagen, superintendent, Mary Fletcher Hospital, Burlington, Vt., and secretary, Paul J. Spencer, superintendent, Lowell General Hospital, Lowell, Mass. Trustees are Dr. Albert Engelbach, superintendent, Cambridge Hospital, Cambridge, Mass.; Howard Pfirman, superintendent, Middlesex Hospital, Middletown, Conn., and Dr. Arthur H. Ruggles, superintendent, Butler Hospital, Providence, R. I.

The Massachusetts Hospital Association elected Frank E. Wing, Superintendent, New England Medical Center, Boston, president. Other officers for the new year are: Rev. Donald A. McGowan, director of Catholic Hospitals, archdiocese of Boston, vice president; Dr. William F. Wood, superintendent, McLean Hospital, secretary; Dr. Warren F. Cook, superintendent, New England Deaconess Hospital, Boston, treasurer; Dr. James G. Manary, superintendent, Boston City Hospital, and Mrs. Louise Hornsby, superintendent, St. Luke's Hospital, Middleboro, trustees.

Maryland Blue Cross Moves

The address of the Associated Hospital Service of Baltimore, Inc., the Blue Cross plan, serving Maryland, is now 15 East Fayette Street, according to J. D. Colman, executive director. The new location, a four story building in the heart of the downtown section, was obtained through the Fidelity Trust Company which merged with the Public Bank of Maryland.



These gloves set your surgeons' and nurses' hands free of tiring constriction

About NEOPRENE

Pioneer's more than 8 years experience with neoprene proves it to be a special purpose synthetic that makes gloves definitely superior to those made of natural rubber. Neoprene should not be confused with synthetics used in tires.

Thousands of doctors and surgeons are using these remarkable gloves because they have found that Rollprufs stay snug but relax just enough on the hand to prevent cramping in long operations.

And their soft textured but tough tissue-sheerness provides unusual finger-tip sensitivity.

Besides, experience shows they do not have the allergen which in natural rubber sometimes causes dermatitis of the hands. And the wrists are flat-banded — no roll to roll down and annoy during surgery.

Many users find these important benefits in neoprene Rollprufs — your hospital staff appreciates your giving them a chance to try them.

Your glove budget enjoys neoprene Rollprufs, too. The flat-banded wrists resist tearing. They stand more sterilizings. They last.

Order neoprene Rollprufs from your supplier now — if he doesn't have them, write us.

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SEE OUR CATALOG IN THE HPF HOSPITAL PURCHASING FILE

Pioneer SURGICAL GLOVES

V.A. Construction Projects Turned Over to Army Engineers

By EVA ADAMS CROSS

WASHINGTON, D. C.—Gen. Omar N. Bradley on February 27 turned over Veterans Administration hospital projects totaling $188,278,208 to the Army Engineers for construction. This is the first en bloc assignment of hospital construction for the building program which totals $448,000,000. Funds have already been assigned by Congress for the 35 new hospitals and additions requiring new sites and also for the 17 additions included in the list just turned over to the Army Engineers.

General Bradley has declared that the Veterans Administration will continue to employ surplus Army and Navy hospitals wherever they can be used to accommodate emergency needs. Difficulties in obtaining adequate and competent medical staffs are the limiting factors in the selection of these hospitals.

Construction of 39 other hospitals and additions valued at $140,167,020, now before Congress for approval of funds, is scheduled for completion prior to July 1, 1948. The number of hospitals in the 1947 program, now before Congress, to be turned over to the engineers has not been determined.

Congressional pressure for the Veterans Administration to take over the surplus hospitals continues. The House Appropriations Committee has decided that whenever V.A. proposes to build a new hospital in an area in which there is a surplus hospital, the Bureau of the Budget must notify the committee before the appropriation is cleared. The Veterans Administration will then be called on to explain why it has to build a new hospital in this area where such facilities already exist.

Meanwhile, demands for hospitalization by veterans of World War II are rapidly mounting. Paul R. Hawley, chief medical director, explained that the administration has moved three ways in its efforts to obtain additional hospital facilities for the record number of veterans applying for care. Surplus Army facilities have been requested; the Navy has agreed to make available almost 10,000 beds by September 1, and, as the third step, Doctor Hawley pointed to the contract with the Michigan Hospital Association which permits eligible veterans to go to any one of some 200 Michigan hospitals. This particular program with civilian hospitals is being extended all over the country. Following is the list of new hospitals and additions:

New Hospitals or Approved Additions Requiring New Sites

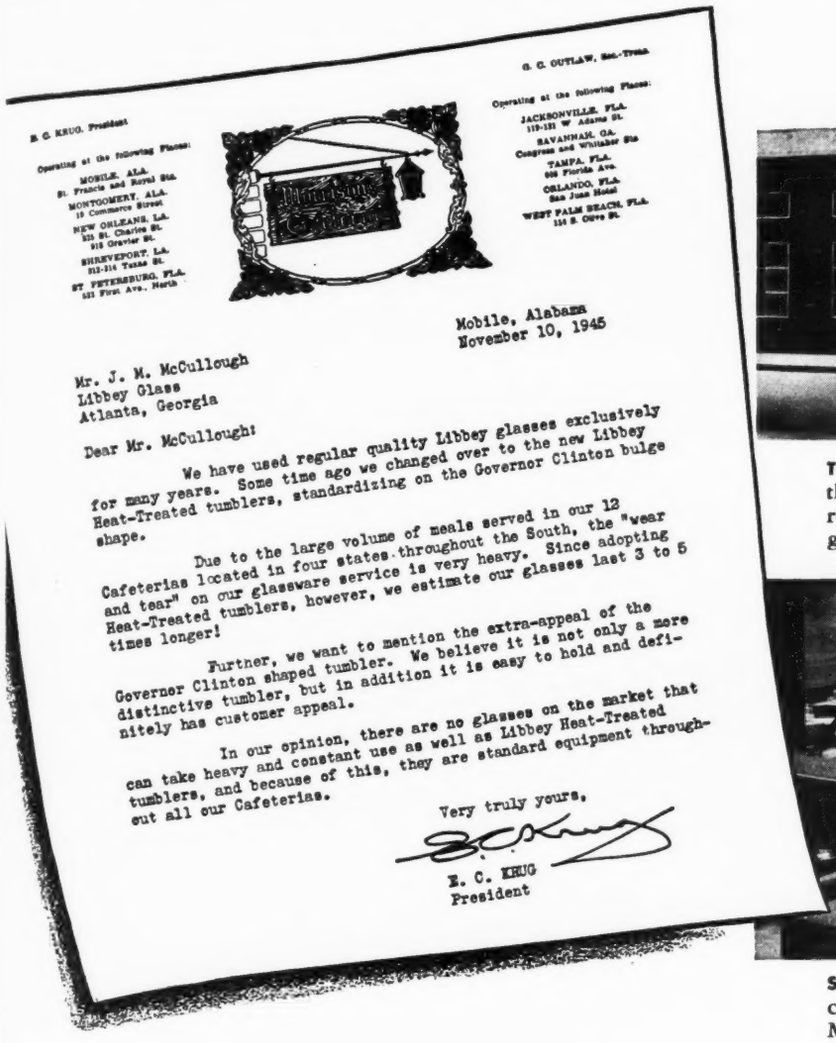
Location	*No. Beds*	*Type of Hospital*
Hines, Ill.	600	GMS
Kansas City, Mo.	495	GM
Kansas City, Mo.	250	TB
Seattle, Wash.	300	GM
Western Pennsylvania	1828	NP
Pittsburgh	1248	GM
Miles City, Mont	100	GM
Big Spring, Tex.	250	GM
Shreveport, La.	450	GM
Metropolitan New York	1000	GM
Alexandria, La.	250	TB
McComb, Miss.	200	GM
Iron Mountain, Mich.	250	GM
Fresno, Calif.	250	GM
Wilkes-Barre, Pa.	475	GM
Southwest Georgia	250	TB
Eastern Connecticut	400	TB
Atlanta	343	GM
New Haven, Conn.	500	GM
Iowa City, Iowa	500	GM
Washington, D. C.	750	GM
Duluth, Minn.	200	GM
Clarksburg, W. Va.	200	GM
Phoenix, Ariz.	200	GM
El Paso, Tex.	500	NP
Baltimore	300	TB
Buffalo, N. Y.	1000	GM
Southern Minnesota	200	TB
Newark, N. J.	1000	GM
Albany, N. Y.	1000	GM
Decatur, Ill.	250	GM
Louisville, Ky.	750	GM
Omaha, Neb.	500	GM
New Orleans	500	GM
Cincinnati	750	GM

(*Continued on Page* 154.)

None can take as heavy use as

LIBBEY HEAT-TREATED TUMBLERS!

says E. C. Krug, President
Morrison's Cafeteria



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Mobile, Alabama
November 10, 1945

Mr. J. M. McCullough
Libbey Glass
Atlanta, Georgia

Dear Mr. McCullough:

We have used regular quality Libbey glasses exclusively for many years. Some time ago we changed over to the new Libbey Heat-Treated tumblers, standardizing on the Governor Clinton bulge shape.

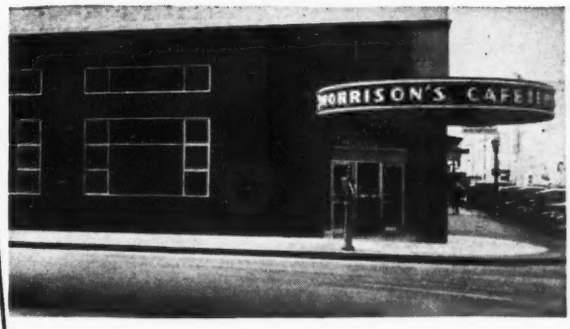
Due to the large volume of meals served in our 12 Cafeterias located in four states throughout the South, the "wear and tear" on our glassware service is very heavy. Since adopting Heat-Treated tumblers, however, we estimate our glasses last 3 to 5 times longer!

Furtner, we want to mention the extra-appeal of the Governor Clinton shaped tumbler. We believe it is not only a more distinctive tumbler, but in addition it is easy to hold and definitely has customer appeal.

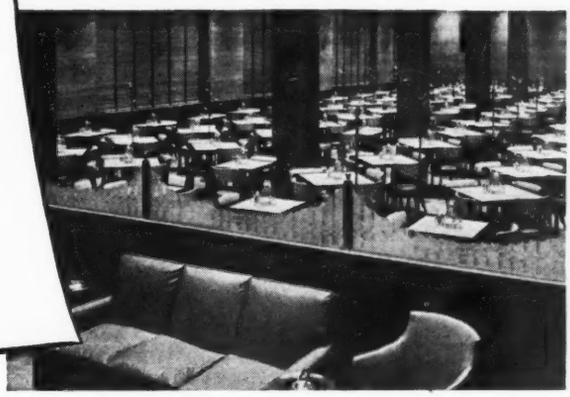
In our opinion, there are no glasses on the market that can take heavy and constant use as well as Libbey Heat-Treated tumblers, and because of this, they are standard equipment throughout all our Cafeterias.

Very truly yours,

E. C. KRUG
President



Typical of the Morrison's Cafeteria Chain—is this modern exterior of the Mobile, Alabama, restaurant where those who know good food gather to dine.



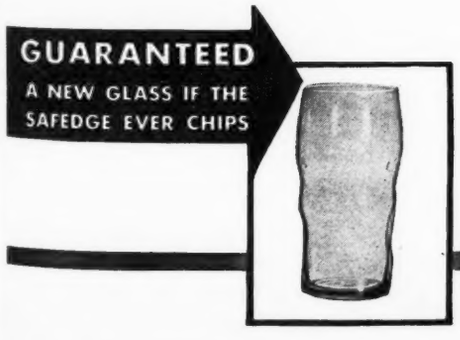
Serving many thousands of meals daily in de luxe cafeterias like the above—it's no wonder that Morrison's standardize on Libbey Heat-Treated Tumblers exclusively.

THIS LETTER from the Morrison's Cafeteria chain operating throughout Alabama, Florida, Georgia and Louisiana tells at a glance the superiority of Libbey Heat-Treated Tumblers.

Restaurants, hotels, clubs, fountains, bars, and hospitals continue to write us about savings like these since changing to Libbey...the glassware backed by the famous "Safedge" guarantee: "A new glass if the 'Safedge' ever chips."

1. Reduced replacement costs
2. Lowered investment
3. Less breakage
4. Saving on storage space

Look into the advantages of Libbey Heat-Treated Tumblers for your business. Ask your jobber to show you samples or write to us for information.



LIBBEY GLASS

Libbey HEAT-TREATED

TOLEDO 1, OHIO. A division of Owens-Illinois Glass Company

Additions to Existing Hospitals

Location	*No. Beds*	*Type of Hospital*
Northampton, Mass.	314	NP
Tuskegee, Ala.	164	NP
Bedford, Mass.	400	NP
Dayton, Ohio	100	Dom.
San Fernando, Calif.	150	TB
Gulfport, Miss.	164	NP
Lincoln, Neb.	20	TB
Downey, Ill.	164	NP
Roseburg, Ore.	164	NP
Bath, N. Y.	100	Dom.
Biloxi, Miss.	50	GM
Mountain Home, Tenn.	100	Dom.
Lebanon, Pa.	1600	NP
Bay Pines, Fla.	53	Dom.
Salt Lake City, Utah	50	GM
Minneapolis	150	GM
Batavia, N. Y.	294	TB

Gregory to Administer New War Assets Agency

WASHINGTON, D. C.—Lt. Gen. Edmund B. Gregory, former head of the Army's mammoth purchasing activities, is now administrator of the new agency, the War Assets Administration, which was established March 25 and which has absorbed the Surplus Property Administration. President Truman has ordered the dissolution of the War Assets Corporation. In his present position, General Gregory will sell many of the very items he once bought.

In his recent statement before the subcommittee on surplus property of the Senate Military Affairs Committee, General Gregory said that disposal of surplus goods to certain priority claimants is a basic philosophy of the Surplus Property Act. He declared that even more effort would be expended in seeing that hospitals, charitable institutions, schools and colleges had opportunities to benefit through surplus property disposal.

Cotton Fabrics Available

WASHINGTON, D. C.—Hospitals stand to benefit through directive 12 to PR 13 issued by the Civilian Production Administration March 12 which will channel surplus cotton fabric suitable for use in the manufacture of "washable service apparel" to manufacturers of service apparel used in hospitals. As used in this directive such apparel is defined as gowns, suits or coats for doctors, dentists, interns, orderlies, druggists and hospital use. The directive will make available a supply of cotton fabric (sheeting and cotton drill) now held by the War Assets Corporation as surplus property.

House Organ Issued

The first issue of the *News*, house organ of Cedars of Lebanon Hospital, Los Angeles, made its appearance in March.

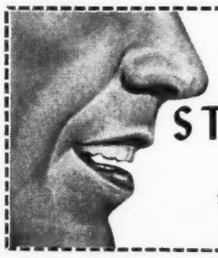
The pulse of the whole hospital is under this nurse's finger!

INSTANTLY—through this new, self-contained Stromberg-Carlson Sound System—*her voice can reach any one, or more, of six selected areas, or gain complete coverage of the entire administrative zone.*

The new, self-contained Stromberg-Carlson Sound System is installed simply, quickly, and with a great saving over former custom-built sound systems. For paging individuals, for locating and directing employees or special groups for emergency action, it eases the load on the floor nurse, and frees her telephone line. Music programs can be carried for recreation and entertainment—as well as controlled music for therapeutic use. And an independent sound system will prove a great aid in staff and administrative meetings, and for general instruction.

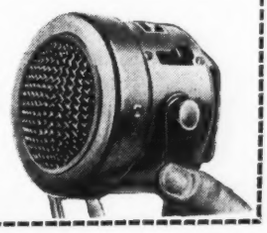
Your local Stromberg-Carlson Sound Equipment distributor can tell you all the advantages of this new packaged sound system. See your local classified telephone directory. Or write, Sound Equipment Division, Stromberg-Carlson Company, Dept. M-4, 320 N. Goodman Street, Rochester 7, New York.

Where voice paging is to originate from a microphone at a point remote from the Standard Cabinet Assembly, the Model 825 Control Turret (shown herewith and in use in the drawing above) permits coverage of six selected areas, or of all speakers simultaneously. The Model 750 Standard System (shown herewith) is a compact unit including amplifier. It is expressly suited to hospital use, and may be located at any convenient point.



STROMBERG-CARLSON

STRAIGHT-LINE COMMUNICATION



Teachers College Announces Course in Institution Management

A six weeks' refresher course for dietitians will be offered at Teachers College, Columbia University, from July 8 to August 16, it has been announced.

Dietitians in civilian hospitals during the war years have been meeting and solving serious problems in connection with shortage of personnel, rationing and rising food costs and, consequently, have had little time to develop new ideas in dietary services, it is pointed out; many others have been working in military hospitals during these years and some feel the need of a brief contact with civilian hospitals before accepting regular positions.

The refresher course has been designed to meet the needs of these groups and to serve as a center for discussion of developments in the hospital dietary field. Presbyterian and Montefiore hospital dietitians will conduct the greater part of the work, but at least a week will be spent in observation in government and voluntary hospitals in the metropolitan area.

The course is open to dietitians whose training and experience are satisfactory to the instructors. Application is to be made to Mary deGarmo Bryan, Teachers College, Columbia University, New York City, before May 15. Students will register for Institution Management s151 which covers classes, conferences and clinics in each hospital and for Institution Management s207G. The former carries two points and the latter four points of credit toward the master's degree at Columbia. Fees, including registration, will be $82.

At Presbyterian Hospital, emphasis will be placed upon food service to patients, the food clinic, the educational program for student nurses, student dietitians and medical students and formula room procedures; at Montefiore Hospital, instruction will be offered in menu planning, ordering, food preparation, food cost accounting, personnel management and diet therapy as applied to a variety of chronic conditions.

International Health Organization Planned

Dr. Thomas Parran, Surgeon General of the United States Public Health Service, is in Paris helping to plan an international conference to be held in June to establish an International Health Organization. The June conference is the outgrowth of the unanimous approval of the United Nations Organization for "international action in the field of health" declared at San Francisco.

Doctor Parran is a member of the technical preparatory committee named by the Economic and Social Council of the U.N.O. to prepare agenda and draw up proposals for the conference. The committee will submit recommendations to all members of the United Nations by May 1 and to the second meeting of the Economic and Social Council which will be held in New York at approximately the same time.

Murray Asks Aid of Health Groups

WASHINGTON, D. C.—Senator James E. Murray, chairman of the Senate committee on education and labor, has asked the American Medical Association, the American Dental Association, the American Hospital Association, the American Public Health Association and 180 other important groups in the health field to join in a cooperative attempt to stake out specific health goals for the coming five years. The purpose of Senator Murray's request is to obtain adequate knowledge of what the nation's health objectives should be in order to enable the Senate committee to give proper consideration to various health bills.

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New York Court Rules Against Credit Exchange

Hospital Credit Exchange, Inc., a collection service affiliated with the Greater New York Hospital Association, is accepting assignments of claims and bringing suits for collection in violation of New York penal laws prohibiting the practice of law by corporations, Judge Haas of the New York Municipal Court declared in a recent decision that may affect the operation of all nonprofit hospital collection services.

The fact that the exchange serves only nonprofit charitable hospitals and distributes its profits to such hospitals does not make it a charitable organization, Judge Haas ruled. If any such interpretation were permitted, he pointed out, any collection agency could thus become a charitable corporation if it undertook to serve only charitable organizations. "This might be a good business for the officials of a closely managed collection agency," the court explained, "who could thus grant themselves very satisfactory compensation for conducting what is tantamount to a law practice."

The decision was handed down when the court dismissed a suit brought by the exchange to collect a bill from a former patient of the Beth Moses Hospital of Brooklyn. Attorney for the defendant charged that assignment of the claim to the Hospital Credit Exchange was illegal and the exchange was illegally practicing law.

"It seems plain to me that the plaintiff [exchange] is conducting the business of an ordinary collection agency," the decision read in part. "It should be said in fairness to plaintiff and to the numerous public-spirited citizens who have interested themselves in this case that the plaintiff was organized with the best of intentions. Undoubtedly [it] saves money for the charitable hospitals it serves. The officers and trustees of the various hospitals strongly approve of the plaintiff; its officials and employes are apparently honest and efficient. Nevertheless, the plaintiff must yield to the public policy which interdicts the practice of law by lay agencies. Balancing the conveniences and weighing the respective public interests involved, I am constrained to the conclusion that to tolerate the practice of law by this plaintiff is to set a most dangerous precedent and to sanction a clear, though well-intentioned, violation of statutes."

Officials of the exchange and the Greater New York Hospital Association have not stated whether or not the decision will be appealed.

A.M.A. Sponsors Rural Health Meeting

Rural medical care is one of the most important health problems in the nation today, Dr. F. S. Crockett of Lafayette, Ind., declared at the first annual National Conference on Rural Health sponsored by the American Medical Association in Chicago March 30. Doctor Crockett, who is chairman of the association's committee on rural medical service, emphasized that improvement of rural health conditions depended on coordinated efforts by all the interested groups.

Representatives of state medical societies and American Farm Bureau health groups from all over the country attended the conference. In addition to Doctor Crockett, speakers included Ransom Aldrich of Jackson, Miss., chairman of the medical care committee of the American Farm Bureau Federation; Dr. Frederick Mott of the U. S. Public Health Service, who is chief medical officer of the Farm Security Administration; Dr. Victor Johnson, secretary of the A.M.A.'s Council on Medical Education and Hospitals, and Howard Strong, secretary of the health council of the U. S. Chamber of Commerce in Washington, D. C.

A.M.A. Announces Plan for Temporary Approval of Residency Programs

A plan for temporary approval of hospital residencies, designed to meet the demand of returning medical officers for residency training, was announced by the Council on Medical Education and Hospitals of the American Medical Association in March. The program was developed in collaboration with the executive committee of the Advisory Board of Medical Specialties, and most specialty boards have already approved the proposal.

As reported in the *Journal of the American Medical Association*, the plan provides:

1. Authority for the secretary of the Council on Medical Education and Hospitals to grant approval of residencies, subject to agreement of the appropriate American board.

2. A representative of each American board with authority to act for the board in granting temporary approvals.

3. Temporary approval to be given without inspections on the basis of information from the hospital on personnel, facilities and educational programs.

4. Subsequent regular inspection by the council staff toward joint action by the council and board either to change the temporary approval to full approval or to withdraw it entirely.

5. Credit toward board certification for all time served in temporarily approved residencies, in event approval is withdrawn, with a reasonable time allowed after withdrawal for the resident to obtain another acceptable appointment.

The granting of temporary approval without inspection in no way indicates that standards have been relaxed, it is emphasized. "Such approval will be granted only if the representatives of the council and of the board are reasonably satisfied that the educational program fulfills the standards of both bodies," the *Journal* report states. Hospitals seeking temporary approval must make the same application that has always been made in the regular approval procedure, it is added.

COMING MEETINGS

AMERICAN COLLEGE OF SURGEONS, Regional Meetings: Utah Hotel, Salt Lake City, April 8-9; Hotel Multnomah, Portland, April 12-13; Biltmore Hotel, Los Angeles, April 17-18.

AMERICAN DIETETIC ASSOCIATION, Netherland Plaza Hotel, Cincinnati, Oct. 14-18.

AMERICAN HOSPITAL ASSOCIATION, Hotels Bellevue-Stratford and Benjamin Franklin, Philadelphia, Sept. 30-Oct. 3.

ARKANSAS HOSPITAL ASSOCIATION, Hotel Lafayette, Little Rock, May 16-17.

ASSOCIATION OF CALIFORNIA HOSPITALS, San Francisco, April.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, May 14-16.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Hotel Poinsett, Greenville, S. C., May 22-23.

CATHOLIC HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, June 10-13.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Hotel Bellevue-Stratford, Philadelphia, April 24-26.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 15-17.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Brown, Louisville, April.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, April 24-26.

NATIONAL CONFERENCE OF SOCIAL WORKERS, Buffalo, N. Y., May 19-25.

NATIONAL COUNCIL OF CATHOLIC NURSES, Hotel Commodore Perry, Toledo, Ohio, May 24-26.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Atlantic City, May 21-23.

NEBRASKA HOSPITAL ASSEMBLY, Sectional Meetings: Lincoln, Holdredge, Lexington, Alliance, Norfolk, May. Annual Conference: Oct. 21-22.

NEW JERSEY HOSPITAL ASSOCIATION, Hotel Dennis, Atlantic City, May. 1-3.

NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Andrew Johnson, Knoxville, April 8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

New Mercy Hospital Will Adjoin N.U. Medical Center

Sisters of Mercy, operators of the oldest hospital in the Chicago area, have purchased property on Chicago's Near North Side and will construct a 500 bed hospital costing at least $5,000,000, according to a recent announcement.

Construction, to start in 1948, will be completed in 1950. A fund-raising campaign will begin within a few months under the direction of Mother Mary Genevieve, provincial of the Chicago province of the Sisters of Mercy.

The new Mercy Hospital will be the third institution in an area of less than two blocks and will be adjacent to the proposed $95,000,000 Northwestern University medical center described on page 67 in this issue. Passavant and Wesley Memorial hospitals are already situated in this area. Completion of the two new projects will make the district one of the largest medical centers in the world.

The group of buildings planned for the Sisters of Mercy includes a main 20 story structure, a chapel, a convent and a research building. Schmidt, Garden and Erikson of Chicago are the architects.

The present hospital buildings, located in a largely Negro district on Chicago's South Side, will be maintained by the Sisters of Mercy as a community hospital, it was stated. Reasons given for moving to the Near North Side were proximity to the Loop, better transportation and "future plans of the Chicago Plan Commission."

Specialists Aid V.A. Hospitals

WASHINGTON, D. C.—A new program that will bring nationally and internationally known psychiatrists into Veterans Administration neuropsychiatric hospitals on temporary duty will be inaugurated soon, the V.A. announced March 13. The program will get underway with the visit of Dr. Harry C. Solomon, professor of psychiatry at the Harvard Medical School and medical director of the Boston Psychopathic Hospital to the V.A. hospital at Roanoke, Va. He will be the first of the visiting psychiatrists under the new plan.

Kentucky to Make Survey

A division of medical and related services within the Kentucky State Health Department was created by order of the governor last month. Dr. William B. Atkinson, formerly state medical officer for selective service, was named director of the new division, which will conduct the state survey of existing hospital facilities and also make a study of the number and distribution of physicians throughout the state.

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Administrator and Trustees Resign From Cortland Hospital

Three months of open conflict between medical and nursing groups and the board of trustees and administrator of the Cortland County Hospital, Cortland, N. Y., culminated last month in the resignation of Supt. Elmina L. Snow and the entire board of trustees of the hospital, which is operated by a nonprofit association. This action followed publication of a report submitted by a "citizens' committee" appointed to investigate the hospital.

Trouble started last November when the board of trustees adopted a plan designed to alleviate the hospital's nursing shortage, which was severe enough to force the administration to close several departments. The board's plan required that all nursing service within the hospital, including special services, be rendered by hospital employes. Immediately, a petition signed by a group of nurses was presented to the board claiming the plan embodied "closed control" of professional service. Eventually, private duty nurses refused to work in the hospital, and the citizens' group was appointed to study conditions.

As a result of its study, which supporters of the administration maintained was strongly influenced by members of the medical staff, the committee recommended that private duty nurses be permitted to come and go with no restriction or control by the hospital; further recommendations would have given the medical staff direct authority in administrative matters.

"Since the recommendations of the committee are of a character which might be difficult for this board to undertake to the satisfaction of all concerned," the trustees said in their letter of resignation, "we feel that it would be in the interest of the general good for a new board to be elected, as it is evident to us that we do not enjoy the confidence and support of the general public, the staff and the special duty nurses."

Appointed by the mayor and chairman of the county board of supervisors, the committee consisted of lay investigators from Cortland and near-by communities in the county and did not include, administration supporters pointed out, any impartial hospital experts.

New York Group Plans Public Relations

The sum of $20,000 annually is now assured the Greater New York Hospital Association with which to organize a public relations program, according to Father J. J. Curry, Catholic Charities, New York City. As reported last month, the United Hospital Fund acted favorably on the request of the association for a grant of $10,000 annually for three years.

At that time it was erroneously reported that the American Hospital Association had been asked for a grant of $7000. This request was presented to the Associated Hospital Service of New York and its acceptance has now been received. The association is making up the remaining $3000 to meet the budget of $20,000. Efforts are now being made to find a qualified person for the position of executive secretary. Final decision on this matter is expected about May 15.

Little change in the personnel situation was reported before the last meeting of the Greater New York Hospital Association and shortages continue serious. "Hospitals must realize that if they are to obtain sufficient personnel the rate of pay must be comparable to rates paid by industry," stated John McCormack, Presbyterian Hospital. Another feature to which hospital workers object is that which makes them take part of their wages in perquisites. The practice of paying all help completely in cash is recommended.

ST. THERESE'S HOSPITAL
Waukegan, Illinois

This 200-bed hospital, built on a 14-acre site, is operated by The Missionary Sisters, Servants of the Holy Ghost. Keeping step with modern developments, the rooms of this hospital are gradually being treated with FABRON, supplying them with an attractive, sanitary, plaster-protecting and economical decoration.

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Introduces Bill on Hospital, Medical Care of Veterans

WASHINGTON, D. C.—A bill purporting to clarify the laws pertaining to hospital treatment, medical care, domiciliary care and related services was introduced March 6 by Congressman Rogers of New York. The bill which covers considerable territory would make any center, hospital, home or clinic, now or later under contract, control and jurisdiction of the Veterans Administration, War Department, Navy Department or the Public Health Service, available for the admission of any honorably discharged veteran of any war since 1897.

The bill then seeks to reorganize the Federal Board of Hospitalization and to give in detail a construction program for some 75 Veterans Administration hospitals, their proposed locations and bed capacity. The bill, H.R. 5685, authorizes a sum not to exceed $550,000,000 for this program. It would also establish six diagnostic, research and proving centers by transferring certain Army and Navy hospitals to the Federal Board of Hospitalization.

Officials at the Veterans Administration declared the bill was news to them and that the V.A. had no connection with it.

National Nursing Council Names New Officers

Sophie C. Nelson, director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company, Boston, succeeded Stella Goostray as council chairman at an adjourned annual meeting of the National Nursing Council March 1 at the Hotel Pennsylvania, New York City. Miss Goostray, who is superintendent of nurses and principal of the School of Nursing at Children's Hospital in Boston, has served as council chairman for the last three and one half years.

Other officers elected by the National Nursing Council follow:

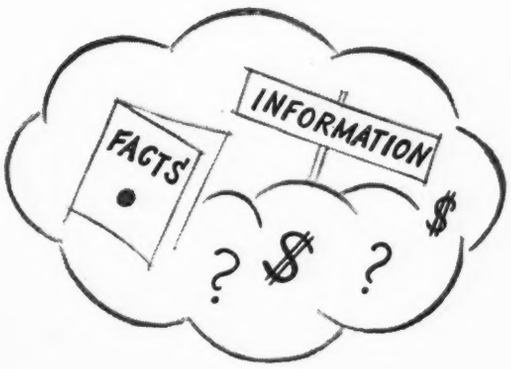
Vice chairman, Anna D. Wolf, director, School of Nursing, Johns Hopkins Hospital, Baltimore; secretary, Pearl McIver, chief, office of public health nursing, U. S. Public Health Service; treasurer, Henry B. Stimson, investment counselor, New York City, and assistant treasurer, Marian G. Randall, executive director, Visiting Nurse Service of New York.

Directors named are Katharine J. Densford, dean, School of Nursing, University of Minnesota; Miss Goostray; James A. Hamilton, James A. Hamilton and Associates, hospital consultants; Lucile Petry, chief, division of nursing, U. S. Public Health Service; Marion W. Sheahan, director, division of public health nursing, New York State Department of Health; Ruth Sleeper, assistant principal, School of Nursing, Massachusetts General Hospital; Mrs. Mabel K. Staupers, executive secretary, National Association of Colored Graduate Nurses.

152 Resident Physicians Serving in V.A. Hospitals

One hundred and fifty-two full-time resident physicians are now on duty in eight Veterans Administration hospitals as an important part of the V.A. program to give hospitalized veterans the best medical care obtainable, according to a recent report of Dr. Paul R. Hawley, chief medical director. In addition, 155 senior consultants and 86 attending men or junior consultants have been appointed and are on duty.

With the filling of these part-time positions, the "deans' committees" can now rapidly fill vacancies for resident physicians. Upon completion of the projected hospital construction program, the Veterans Administration expects to have at least 1000 full-time resident physicians on duty and 500 part-time attending men who are also teachers in Class A medical schools.



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Examine Nurses for Appointment to U.S.P.H.S. Nurse Corps

Oral and physical examinations for the appointment of nurses to the regular commissioned corps of the U. S. Public Health Service were scheduled during March and April in 15 cities throughout the nation, and written examinations will be held on April 15, 16 and 17 at places convenient to the candidate and the service.

Positions are open in marine hospitals of the service for nurses in the grades of junior assistant nurse officer, comparable to the rank of Army second lieutenant; assistant nurse officer, comparable to first lieutenant, and senior assistant nurse officer, comparable to captain; positions are open also for nurses in public health nursing and for certain special projects of the Public Health Service.

Salaries are the same as for officers of the comparable rank in the Army, ranging from $1800 to $2400 a year base pay with maintenance or with allowance for rental and subsistence. Appointments are permanent, but officers may resign at any time except during a war emergency.

Langer Sponsors Three Medical Bills

WASHINGTON, D. C.—Three separate bills were introduced in the Senate March 1 by Mr. Langer authorizing the appropriation of $3,750,000,000 each for the making of studies relating to the prevention, diagnosis and treatment of cancer; for use in combating infantile paralysis; to protect the public health through the detection of certain diseases. The funds appropriated for the study of cancer and the funds for the detection of certain diseases would be administered by the U. S. Public Health Service. The funds authorized for the infantile paralysis legislation would be disbursed by the Secretary of the Treasury upon vouchers approved by Sister Kenny.

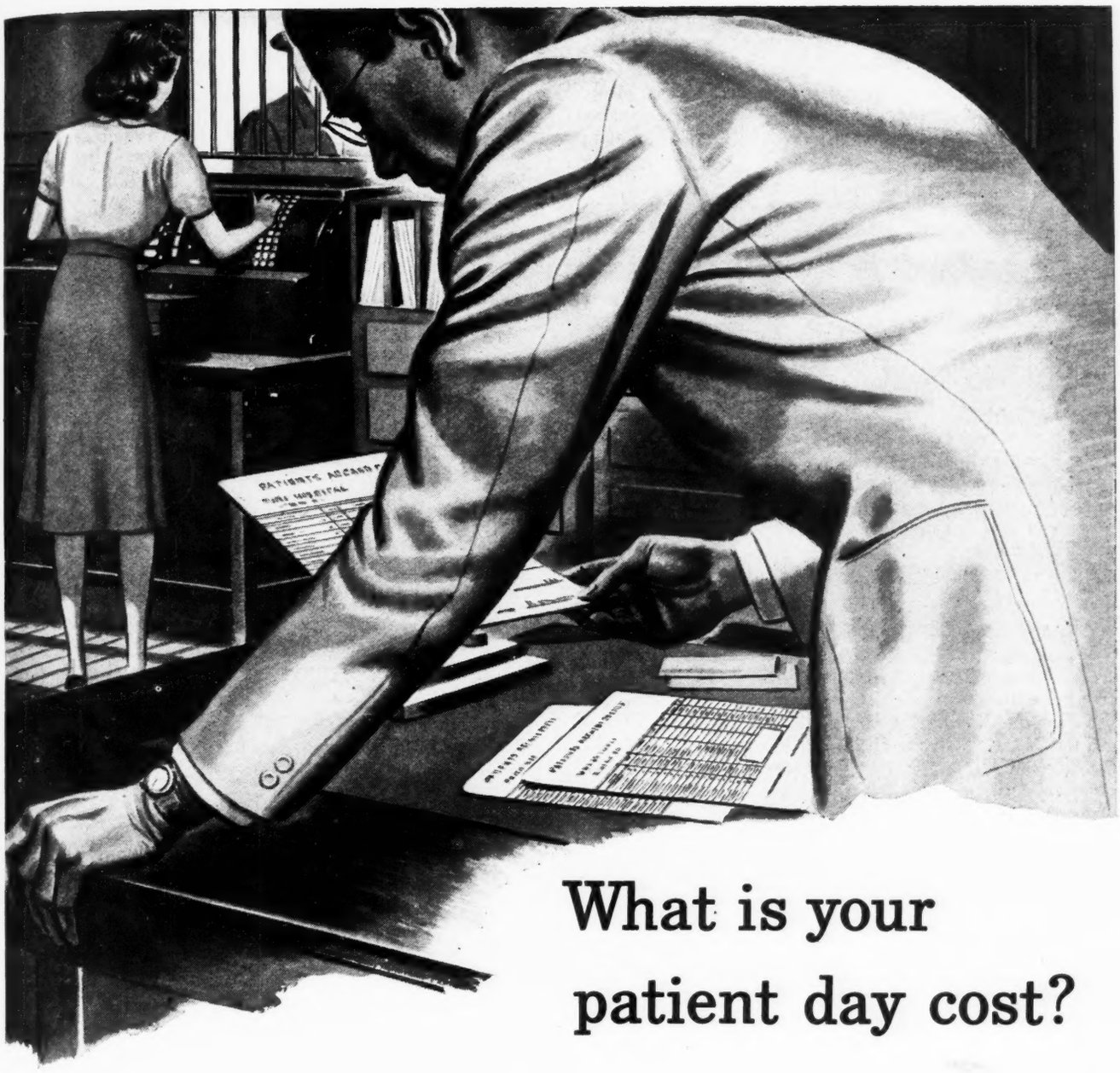
Introduced in the House on March 8 by Representative Stevenson was H. R. 5715 to establish a National Medical Research Foundation for which there would be appropriated $100,000,000. The bill would provide for the mobilization of the scientific resources and knowledge of the United States for the purpose of seeking the causes and cure of cancer, poliomyelitis and certain other diseases.

The National Medical Research Foundation would be established in the executive branch of the government. Its governing board would consist of the surgeon general of the U. S. Public Health Service, the president of the American Medical Association and the president of the American Cancer Society. The members of the board would serve without compensation but the director of the foundation would receive $15,000 per annum.

New Jersey Plan Revises Payments

A revised schedule of payment for hospital services rendered on eligible hospitalization for which admission arose subsequent to March 1, 1946, has been announced to the 193 cooperating hospitals of the Hospital Service Plan of New Jersey.

The increase in payment pertains only to hospital stays of from two to ten days, according to H. Theodore Sorg, president of the plan. The purpose, he explained, is to provide an increased payment by the plan to the hospitals for the majority of cases served through the plan. It will also provide maximum benefits at minimum cost to the subscribing public because those cases of from two to ten days' stay, in proportion to cases of longer duration, often require higher hospital bills owing to the necessity for certain hospital services, particularly in cases involving an operation. Payments for hospital stays of one day or of more than ten days remain unchanged.



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Wisconsin Blue Cross, Surgical Care Plans Combine Service Benefits

Wisconsin's Blue Cross plan for prepaid hospitalization, and Surgical Care, the surgical-medical plan sponsored by the Medical Society of Milwaukee County, have combined their nonprofit service benefits under a single health program and have begun joint enrollment activities throughout the state.

"In offering to cover medical services along with surgery," James O. Kelley, executive secretary of the medical society, stated, "we are the first organization in the United States to do so without increasing the monthly fee."

Under the joint service, Blue Cross acts as the enrolling and billing agent for both plans, thus permitting a single pay-roll deduction. Each group, however, remains an independent plan with administration in the hands of the respective organizations.

Physicians on Round Table

"Management's Responsibility in the Medical Care of Its Employes" is the subject for discussion on the University of Chicago's Round Table broadcast over the N.B.C. network at 12:30 p.m. (C.S.T.) Sunday, April 14. With the American Association of Industrial Physicians and Surgeons as co-sponsors with the university, the program presents Dr Leo Price, medical director of the Union Health Center, New York City; Dr. Joseph Chivers of the Crane Company, Chicago; Dr. Franklin McLean of the university's medical school; Dr. John J. Wittmer of the Consolidated Edison Company, New York, and Dr. Edward C. Holmblad, managing director of the American Association of Industrial Physicians and Surgeons. The broadcast winds up the annual convention of the association.

Menninger Receives D.S.M.

WASHINGTON, D. C.—Brig. Gen. William C. Menninger, director of the neuropsychiatric division, Office of the Surgeon General, U. S. Army, has been awarded the Distinguished Service Medal. He was cited as having been primarily responsible for solving one of the most serious medical problems faced by the Army in developing and putting into effect a treatment plan for neuropsychiatric cases. His program resulted in restoring many thousands of mentally sick men to health and usefulness. Head of the Menninger Psychiatric Hospital in Topeka, General Menninger was commissioned into the Army Medical Corps in November 1942.

OFFICIAL ORDERS

Home Canning.—A new amendment March 11 to revised General Ration Order 5 permits hospitals and other institutions (except Group I) to apply for sugar for home canning for 1946 in the same manner and on the same basis as they were permitted to apply for home canning allotments last year. Application must be made on O.P.A. form R 1340 to the District Office on or before Oct. 31, 1946.

Meat.—To help meet critical food needs abroad, the set-aside of pork required of federally inspected meat packers was increased and the current set-aside percentages on beef, veal and mutton were extended to 10 states formerly exempted.

Molasses.—Anyone wishing to purchase molasses at the U. S. Marshal's sale in Louisiana should apply to the United States Department of Agriculture for specific authorization under the provisions of War Food Order 51.

Price Controls.—A new edition of the Directory of Commodities and Services was issued March 12. This may be obtained at a cost of $1.25, which includes six monthly supplements to follow, from the Superintendent of Documents, Washington, D. C. It lists about 1500 items no longer under price control and the many thousands of commodities and services which are still governed by the O.P.A.

In an action effective February 25 O.P.A. required wholesalers and retailers to absorb the reconversion increase of 5 per cent over their 1941 prices on metal household furniture. This will now be on the market at prices in line with those charged in March 1942.

The ceiling on canned meats at all levels of sale except retail was increased as of March 14, according to an O.P.A. announcement.

Textiles.—An upward revision in the ceilings for almost all cotton textiles and yarns was announced by the O.P.A. on March 8. Most of the increase will be passed on to consumers in the form of higher prices for household items and piece goods.

Settle Government · Antitrust Suit Against A.S.T.A.

Settlement of a government antitrust suit against the American Surgical Trade Association and several of its corporate members was effected in Philadelphia March 18 when the court accepted the defendants' plea of *nolo contendere* and assessed nominal fines, at the same time dismissing its suit against individual officers of the defendant companies.

Brought originally in 1941, the government suit was aimed at the association's plan for registration of new and improved surgical instruments. The association claimed that the plan was designed to stimulate the development of new products, and that registered instruments represented only a fraction of 1 per cent of the total volume of surgical supplies sold by association members during the period the plan was in effect.

"In view of the fact that the Department of Justice was willing to dismiss the indictment of individual defendants, the corporate defendants felt justified in pleading *nolo contendere* and accepting small fines, rather than going through a long and expensive trial," declared an association statement released following the settlement.

Extend Blue Cross Benefits

Minnesota Hospital Service Association has recently announced a new comprehensive coverage contract which gives "practically complete service benefits" to subscribers, according to Margaret Reagan, director of public education. In addition, it is announced, an individual contract offers continued Blue Cross protection to widows of subscribers, pensioned and retired subscribers. The changes are being introduced through a series of luncheons and dinners for group leaders, who then canvass their groups to determine how many members wish to convert to the new coverage.

N. Y. Fund to Open Drive

In preparation for the Greater New York Fund's 1946 campaign which will be launched officially the week of April 29 under the leadership of N. Baxter Jackson as general campaign chairman and will continue through June 7, the fund's report for 1945 has been mailed to approximately 25,000 business leaders, campaign workers and officials of the 415 local, voluntary hospitals, health and welfare agencies in behalf of which the fund will appeal. As a result of the 1945 campaign, gifts totaling $4,810,518.29 were received as compared with $4,661,943.64 in 1944.

ABOUT PEOPLE

(*Continued From Page* 92.)

State College and has served four and one half years in the Army, having been stationed at Hawaii.

Miscellaneous

Dr. Harry Goldblatt has been appointed director of the Institute of Research at Cedars of Lebanon Hospital, Los Angeles, and will assume his duties on September 1. At present, he is associate director of the Institute of Pathology and professor of experimental pathology at Western Reserve University, Cleveland.

London P. Corbett has been appointed director of personnel and public relations of California Hospital, Los Angeles. He succeeds **Frank G. Swain** who is now business manager of a medical clinic at Santa Monica, Calif.

Maj. Emma E. Vogel, director of medical department physical therapists, Office of the Surgeon General, received the Legion of Merit for her work in organizing "the Physical Therapists Branch and formulating policies and plans to ensure the highest standards of treatment for the sick and wounded."

No other floor offers so much to hospitals

A PRACTICAL FLOOR for hospitals must be sanitary and easy to clean. It also must stand up under the wear of constant traffic. And it should be comfortable and quiet underfoot. Armstrong's Linotile* (Oil-Bonded) meets all these requirements and, in addition, this floor offers unusual beauty. It has been used in leading hospitals all over America for nearly thirty years.

It's easy to keep a floor of Linotile clean and sanitary, because it has a smooth, mirror-like surface. The tight-fitting joints between the blocks do not catch dirt and are almost invisible. Linotile is not harmed by spilled liquids and is highly resistant to stains.

The dense composition of Linotile resists indentation and stands up under the punishment of heavy traffic. Yet the comfort of patients and staff alike is promoted by this floor, for its resilience cushions every footstep.

And since a floor of Linotile is laid a block at a time, it offers almost limitless design possibilities. Any of the variety of rich colors can be combined to harmonize with individual decorative schemes.

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Linotile floors are particularly desirable for hospital corridors and public areas. This corridor in the Mount Zion Hospital, San Francisco, has Linotile in a dignified design.

ARMSTRONG'S LINOTILE (OIL-BONDED)

Dr. Vincent M. Iovine, a veteran of nearly four years in the Army including thirty-two months overseas in Africa, Italy, France and the Rhineland, has been appointed chief of the surgical service of Mount Alto Veterans Hospital, Washington, D. C. He will supervise a staff that will be expanded to four full-time surgeons, six resident surgeons and three attending surgeons.

Warren Healy, who has been affiliated with Associated Hospital Service of New York the last ten years, has been named director of public education of the Kansas Hospital Service Association, Inc., and has assumed his duties at Topeka. As a pioneer of New York's Blue Cross plan, Mr. Healy conducted enrollment programs, planned promotional projects and supervised the training of personnel and the coordination and writing of educational material.

Maj. Helen C. Burns, director of medical department dietitians, Office of the Surgeon General, has been awarded the Legion of Merit for her work in the "organization and establishment of the Dietetic Branch and formulating procedures which resulted in outstanding professional achievements in the dietetic field."

Dr. J. C. Harding has been appointed assistant medical director for auxiliary services in the new department of medicine and surgery of the Veterans Administration and **Dr. M. M. Fowler** is assistant medical director for dental services.

Lt. Col. Johnson F. Hammond, M.C., editor of the *Bulletin* of the United States Army Medical Department, has received the Legion of Merit for his work in developing "this journal into an invaluable means of relaying the latest authoritative medical developments to medical officers all over the world." Colonel Hammond was formerly assistant editor of the *Journal of the American Medical Association.*

Dr. Raymond Allen, dean of the University of Illinois Medical School, Chicago, has been appointed president of the University of Washington at Seattle, effective September 1. Doctor Allen, who was graduated from the University of Minnesota in 1928, is a former dean of Wayne University College of Medicine at Detroit.

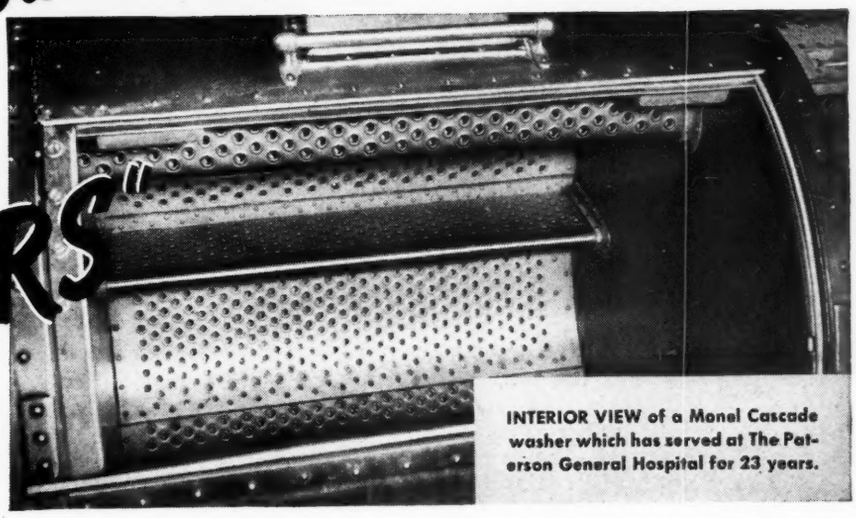
Lucile Petry, head of the U.S. Cadet Nurse Corps, has been appointed chief of the new division of nursing of the U. S. Public Health Service. Her rank while serving as chief of a division is nurse director, the highest held by a nurse in the regular commissioned corps of the Public Health Service and equivalent to that of captain in the Navy and colonel in the Army.

John F. Latcham of Decatur, Ill., has joined the full-time staff of James A. Hamilton and Associates, hospital consultants, New Haven, Conn. Mr. Latcham recently returned from the Army in which he was a captain in the Medical Administrative Corps, serving with the 29th General Hospital in the Pacific. Prior to the war, he was business manager, Colorado General Hospital and the University of Colorado Medical School at Denver.

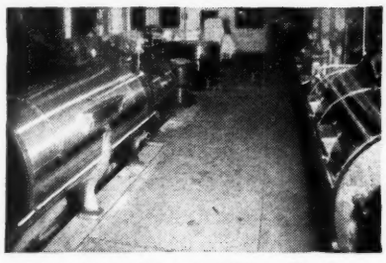
Wayne B. Foster, 30 year old Army veteran and a graduate of Ohio State University, has been named director of Ohio State University's newly established hospital personnel department, the first in Columbus. The appointment is one of the steps being taken at Ohio State toward the erection of the new $5,000,000 medical center authorized by the last session of the legislature. Responsibilities of the new post cover applications, placement, orientation and instruction of new employes.

Col. Curtis H. Nance, who served overseas in both World Wars, has been

"It all comes out in the WASHERS"



INTERIOR VIEW of a Monel Cascade washer which has served at The Paterson General Hospital for 23 years.



PARTIAL VIEW OF LAUNDRY at The Paterson (N. J.) General Hospital, showing some of their Monel washers and extractors.

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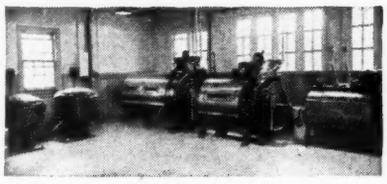
LAUNDRY at The University of Nebraska, School of Medicine, Omaha. Monel-equipped by The American Laundry Machinery Co., Cincinnati, Ohio.



OHIO LAUNDRY ITEMIZES SAVINGS OF THE FIRST YEAR AFTER CHANGE TO MONEL

Out went the old, outmoded washers . . . in went a battery of 4 new Monel machines.

And here are the savings reported at the end of the first year by the progressive Ohio plant which made the change:

POWER—85.93 kw/week at 4¢	$178.88
WATER—4,480 cu. ft./wk. at $1/M	232.96
STEAM—25,480 lbs./wk. at 60¢/M	795.08
SUPPLIES—Savings per week $12	624.00
ANN. CAPITAL CHARGES reduced	47.28
TOTAL	$1878.20

YES, WASHERS are more than mere removers of germs and soil. They can also be used as yardsticks to measure linen life, equipment life, and operating costs.

Profit by following the lead of experienced institutional laundrymen. *Install Monel equipment.*

You'll find it pays in 3 big ways:

—Linens last longer
—You handle them faster
—Costs are lower

And it's easy to see why.

Monel is a strong, tough, *rustproof* nickel alloy. It resists acids, alkalies, laundry bleaches and sours.

Washer cylinders stay smooth. No rough or pitted surfaces will wear or damage your linens. That means they'll last longer.

Monel equipment lasts, too. The washer shown above, for example, has been on the job 23 years. Others have served over a quarter of a century without more than routine repair and maintenance . . . and are *still* turning out first-class work.

For trouble-free performance and long-lasting dependability, Monel's record *throughout the hospital* is unmatched. Count on Monel in the laundry, too, for washers and extractors, starch cookers, trucks and accessories. Its rustless strength and high corrosion resistance protect your linen . . . help you increase your output . . . and ease the strain on your budget.

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Monel

STANDARD METAL OF THE LAUNDRY INDUSTRY FOR MORE THAN A QUARTER OF A CENTURY

appointed deputy administrator in charge of Veterans Administration Branch Office No. 1 at Boston which supervises V.A. affairs in Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island.

Col. Thomas J. Cross, a member of the Regular Army on loan to the Veterans Administration, has been appointed as acting deputy administrator of the San Francisco V.A. Branch Office succeeding **Col. Edwin K. Wright,** who has been recalled by the Army for an undisclosed assignment.

Dean W. Paul Briggs of the school of pharmacy of George Washington University has been given the assignment of chief pharmacist of the Veterans Administration under the newly created Department of Medicine and Surgery and will direct professional pharmaceutical services supplied in Veterans Administration facilities throughout the country.

Dr. Paul Jahnke, faculty member of the University of Nebraska College of Pharmacy, has been awarded the 1945 Ebert Prize by the American Pharmaceutical Association for his research on the sclerosing agent, sodium morrhuate. **Howard Jensen,** former graduate student now in the Navy, was given special mention as collaborator and co-author of the experimental paper which was published in the Scientific Edition of the *A. Ph. A. Journal.*

James U. Norris, retired superintendent of Woman's Hospital, New York City, is now affiliated with Associated Hospital Service as a special representative of the hospital department.

Dr. H. M. Weaver, senior administrative assistant and assistant professor of anatomy, Wayne University College of Medicine, Detroit, has been named assistant to the medical director of the National Foundation for Infantile Paralysis. Doctor Weaver's work will be with the National Foundation's research program and fellowship training for physicians and research workers.

Jay Ketchum, executive vice president of Michigan Medical Service, Detroit, has been appointed director of the newly created Division on Prepayment Medical Care of the American Medical Association, it was reported in the March 19 *News Letter* of the A.M.A.'s Council on Medical Service and Public Relations. "This appointment, announced by the executive committee of the board of trustees, became effective March 15," the *News Letter* says. "Mr. Ketchum will serve on a part-time basis according to arrangements made with the Michigan Medical Service. His particular duties for the present will be to coordinate existing medical care plans in states and to aid states in establishing their own prepayment medical care plans."

Deaths

Dr. Charles F. Read, superintendent at Elgin State Hospital, Elgin, Ill., died recently at the age of 69. Doctor Read had served for more than forty years as a supervisor of state institutions in Illinois, including state hospitals at East Moline, Kankakee and Peoria. He was a member of the American Medical Association, the Chicago Neurological Society and the National Committee for Mental Hygiene.

Edward F. Stevens of Wellesley Hills, Mass., a hospital architect and frequent contributor to The MODERN HOSPITAL in the past, died February 28. He had been in ill health since his retirement three years ago.

Ralf Couch, administrator of the University of Oregon Medical School Hospitals and a nationally recognized authority on hospital administration, died recently after a prolonged illness. He was a member of the American College of Hospital Administrators, the American Hospital Association, Western Hospital Association, Oregon Association of Hospitals, Portland Council of Hospitals, Northwest Hospital Service Plan and Oregon State Defense Council.

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THE IDEAL BABY FEEDING METHOD

Save nurses' time and give babies maximum protection with TUFFY nursers and TUFFY-KAPS. Here's why this perfect nursing team can't be beat:

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2. From filling time to feeding time, TUFFY-KAPS guard nipples from dust, germs and odors and give babies better health protection. TUFFY-KAPS fit tightly over nipples and can be removed in a jiffy, immediately before feeding.

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Low in cost and long-lasting, TUFFYS and TUFFY-KAPS are easier and safer for baby feeding. TUFFYS list at only $12.65 per gross and TUFFY-KAPS at $6.73 per gross. Send today for free samples and the name of your nearest dealer.

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THE BOOKSHELF

ACCOUNTING, STATISTICS AND BUSINESS OFFICE PROCEDURES FOR HOSPITALS. *By Charles G. Roswell, B.S., LL.B., C.P.A. United Hospital Fund of New York, New York. 1946.*

The author states in the preface: "The ever-increasing need for adequate financial facts, as well as the current demands for data concerning operating costs, makes it imperative that both accounting and statistical records be kept in sufficient detail so that financial and cost reports may be conveniently and accurately prepared."

Mr. Roswell's discussion of internal controls in Chapter 2 gives a concise, clear story of what internal controls are and how they operate with respect to cash receipts, accounts receivable and accounts payable. His coverage of staff requirements, assignment of work and work progress charts, and physical requirements of accounting office space is excellent.

This reviewer is not entirely in accord, however, with the suggested floor plan (Form 5, p. 18). The admitting office or offices and separate waiting room for admitting offices should be closely integrated with the cashier's cage. Because the work of cashiers, admitting clerks and credit and collection department is so interrelated, the credit manager's office should also be closely integrated with the admitting offices and cashier's cage. In larger hospitals (300 beds and up) separate waiting rooms to serve the admitting offices and credit manager's office might well be provided.

Hospital administrators and trustees will do well to pay heed to the excellent material on "The Balance Sheet" and "Depreciation and Other Accounting Reserves." Discussion on depreciation allowances on equipment and buildings is particularly well covered by the author. He states: "In the light of recent developments it now appears desirable for all hospitals to recognize depreciation on buildings as an item of operating cost and to consider this expense when arriving at rates to be charged for hospital services."

With an increasing number of patients' bills being paid for by compensation and other commercial insurance carriers, Blue Cross plans, federal, state and local governments and industry, Mr. Roswell's comments on depreciation allowances on equipment and buildings are timely.

Many important items often overlooked by administrators and trustees are discussed in the chapter on "Permanent and Temporary Funds" (endowments). The chapters on "Income and Expense Statements," "Classification of Income and Expense," "Cash Records and Procedures," "Accounts Receivable and Payable," "Payroll and Personnel Records," "Purchasing, Receiving and Storeroom Procedures" and "Inventory Control" will if studied carefully result in real economies in any hospital.

The chapter on "Credits and Collections" presents this troublesome (in normal times) problem in a direct, masterly fashion. Doing the things outlined by the author can well mean the difference between a 4 or 5 per cent write-off for bad debts and less than 1 per cent loss.

Budgeting, a little understood problem in many hospitals, is treated in comprehensive and easily understood manner.

While the final chapter, "Computation of Costs," presents the more complicated method of preliminary and final apportionment of costs in a splendid manner, this reviewer believes that the value of this part of the book would have been considerably enhanced by a presentation of the simpler method of the direct spreading of costs of non-revenue producing departments to the revenue producing departments. The

differences in the final figures resulting from the two methods might well have been explained.

On the whole, this exposition ties in well with the American Hospital Association's "Manual on Accounting" and will no doubt hasten the work of revising the A.H.A. recommendations. Every hospital administrator, accountant, bookkeeper and board treasurer should study this outstanding book.—E. W. Jones.

Operating Room Technique. *By Edythe Louise Alexander, R.N. Reprinted by the publisher, C. V. Mosby Company, St. Louis. Pp.* 392 *with* 221 *illustrations.* $3.75.

This book is all that its name implies. Complete details of operating room technic with illustrations showing instruments for each type of operation and every step in the procedures are included. The general arrangement of the room and its care, a history of asepsis, sterilization, equipment and personnel, duties, procedures and materials required are covered by text and illustrations. It is a comprehensive text and reference volume for operating room personnel, nursing schools and administrators, staff members and department heads responsible for this vital phase of patient care.—Bessie Covert.

The New York Hospital, a History of the Psychiatric Service, 1771-1936. *By William Logie Russell. New York: Columbia University Press.* 1945. *Pp.* 556.

This book tells a moving story, not only of the history of the psychiatric service of the New York Hospital, but also of the trials of the early leaders of psychiatry in the United States, and the progress of their latter-day successors.

While attention is given to all the details commonly pondered upon by hospital administrators, the author, a psychiatrist, highlights the human side of the story. The reader follows, step by step, the development of many important procedures in the hospital care of the mentally ill: the improved technics for the care of the disturbed patient, the adequate provision for the classification of various types of patients, the ascendancy of medical men to the directorship of the psychiatric hospital, the development of psychiatric nursing and many other innovations.

Particularly striking is the number of prominent psychiatrists who have been associated with this important institution.

One must agree with the author that, "Inspiration and encouragement may be derived from contemplating the noble sentiments, sound judgment and earnest endeavors of those by whom the service has been developed from humble beginnings to its present high distinction and usefulness."—Nathan Roth, M.D.